AUTHORIZAION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Compliant with 45 C.F.R. 164.508 (HIPAA)

Person giving this authorization:

Name (if patient is minor, etc.): _____

Relationship to patient: _____

Patient Name: _____

Address: _____

SS#: _____ Date of Birth: _____

Phone #: _____

Entity authorized to release PHI:

HPT Physical Therapy Specialists, Inc.
2240 Fifth Avenue
Huntington, WV 25703

Entity authorized to receive PHI:

Name: _____

Address: _____

Phone/Fax: _____

Information is to be (check all that apply):

□ Paper copy □ On Disc (additional charge may apply) □ On USB drive (supplied by patient)
□ Faxed □ Mailed □ Emailed _____
(Only documentation created after 4/10/17 can be emailed via a secure Document Portal. Documentation created prior to 4/10/17 will not be emailed; you will need to choose a different mode of delivery.)

Specific and meaningful description of the PHI to be disclosed:

_____

Reason for disclosure of PHI:

_____

Expiration date of authorization (not to exceed 1 year): _____

Revocation: This authorization can be revoked at any time by the person giving it by providing a signed revocation to the entity authorized to release PHI. Revocation will not apply retroactively to PHI already released in reliance on this authorization.

Re-disclosure: This authorization is given with the understanding that all or some of the PHI provided may or will be re-disclosed to organization which, and person who, may not be subject to federal and state PHI privacy laws and therefore that re-disclosure by these organizations or people may not be protected by such laws.

Duplicates: A photocopied, faxed, or electronic duplicate of this authorization is as valid as the original.

Signature: _____ Date:_____