Harbor Physical Therapy & Wellness CLINIC

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Authorization for Harbor Physical Therapy & Wellness Clinic to Disclose or Receive Health Care Information

Patient Name: _____ DOB:_____
Previous Name: _____

I authorize _____ to furnish all *requested* information contained in my medical record to Harbor Physical Therapy & Wellness Clinic.

1) I authorize the use or disclosure of the above named individual's health information as described below.

2) The type and amount of information to be used or disclosed is as follows: (check box and include dates where appropriate)

- ☐ All health care information in my medical record
- ☐ Information in my medical record relating to the following treatment or condition:
  _____
- ☐ Information in my medical record to the date(s)_____
- ☐ Billing from: (date) _____ to (date) _____

Reason(s) for this authorization (check all the apply):

- ☐ At my request
- ☐ Change of Physical Therapy providers
- ☐ Continuity of care (if information is to be sent to anyone other than your referring physician)

3) I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire ninety days after the date the authorization is signed, or sooner, at my election on the following date, event, or condition: _____.

4) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, I understand that I may inspect or receive a copy of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ Date _____
Signature of Patient OR Legal Representative

_____ _____ Date _____
Relationship to Patient *Witness*