Authorization to Disclose Protected Health Information

Patient Name: _____

Description of information to be used or disclosed: Initial Evaluation, Plan of Care, Daily Notes, Status Reports, Discharge Summary

Purpose of Information to be used or disclosed: Physician Approval/Notification, Insurance/Payor Requests

Persons authorized to use or disclose information: Physicians, Therapists and Staff at Physical Therapy Services of West Michigan, Insurances/Payors

Persons to whom information may be disclosed: Physicians, Therapists and Staff at Physical Therapy Services of West Michigan

Expiration date or expiration event: One (1) Year from Today's Date

Right to terminate or revoke authorization

This authorization may be revoked, or terminated, by submitting a written revocation to Physical Therapy Services

Potential for Redisclosure

Information disclosed pursuant to this authorization is subject to redisclosure by the recipient, and may no longer be protective

Your Rights

You have the right to receive a copy of this authorization and to be told the purpose and to whom the protected health information is being disclosed

Refusing Authorization

If you refuse to sign this authorization, you may not be denied appropriate treatment by this facility

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Printed Name of Patient

Signature of Patient or Patient Representative

_____

Date