Restor Physical Therapy

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AUTHORIZATION FOR RELEASE OF RECORDS

This Authorization for disclosure and release of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Section 56 et. Seq., of the California Civil Code, the Health and Safety Code, Section 199.21

I Authorize Restor Physical Therapy to release my private health information as specified below to:
Name: _____ (Doctor, Ins. Agent, Self)

Address: _____

City, State and Zip_____

Fax#: _____ Office#: _____

This authorization is limited to the following information only: ___ Physical Exam ___ X-ray Report / Film ___ Physical Therapy Notes ___ Lab Reports ___ Progress Notes ___ Complete Medical Records ___

Other, please specify: _____

Duration: This authorization is valid from _____ to _____ (not to exceed 1 year)

• I understand that I have the right to receive a copy of this authorization upon my request. • I understand that I may not be required to sign this authorization as a condition to obtain treatment or obtain my eligibility benefits.

• I also understand that I may revoke this authorization in writing at any time by sending a notice to the custodian of records. Such revocation will be effective upon receipt, except to the extent that the recipient has taken action in reliance on this authorization.

• I understand that Restor Physical Therapy is required to keep my health information confidential, and re-disclosure of my health information without my authorization is prohibited by state and federal law.

• I further understand that the potential exists for re-disclosure of my private health information and it may no longer be protected under HIPAA, if I choose to disclose my private health information to someone who is not legally required to keep it confidential. • I also understand that I am entitled to receive notice if my protected health information has been breached.

Signature of Patient: _____ Date: _____

Print Name: _____ DOB: _____

Restor Physical Therapy accepts cash, check, and credit card as a form of payment. Checks should be made payable to Restor Physical Therapy. Please be advised that we may have to get prior approval from a provider if your results have not yet been discussed with you, before releasing your records. It is our policy not to accept subpoenas by mail. Any subpoena must be served in person and delivered to Restor Physical Therapy. Particular diagnoses are protected by specific laws, which may require a different authorization form.