DREVNA HUDSON
PHYSICAL THERAPY

700 Eden Rd
Lancaster, PA 17601
Phone: (717) 569-4184
Fax: (717) 569-4192

AUTHORIZATION FOR RELEASE OF INFORMATION

Authorization is not required for the Use or Disclosure of Information Related to Treatment, Payment, Healthcare Operations or if Required by Law or Rules

This authorization is for the use and/or disclosure of the specific personally identifiable health information set forth in this Authorization and is made pursuant to the requirements of 45 CFR §164.508, which sets out the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 and authorizes Drevna-Hudson Physical Therapy ("the practice") to obtain the personally identifiable health information specifically referenced in this Authorization.

(1) Patient's Printed Name:

_____ _____ _____ _____ _____ _____
Last **First** **Initial** **Date of Birth**

Reason for the Request: _____

(2) Drevna-Hudson Physical Therapy will only disclose the protected health information you want disclosed.
Check only one box to tell Drevna-Hudson Physical Therapy the specific information you want disclosed/released:

□ Do Not release any information other than for treatment or payment (skip #'s 3, 4, and 5)
□ Limited information (Complete ALL Sections)
□ ALL records regarding my care at Drevna-Hudson Physical Therapy to any requesting party (skip 3 and 4)

(3) Complete only if you selected "limited information". Please initial all that apply:

_____ Evaluation/Examination _____ Attendance _____ Correspondence Re: your Physical Therapy Services
_____ Past Medical History _____ Treatments _____ Other _____

(4) Complete only if you selected "limited information". I only authorize the release of information to the individuals/entities identified below by name:

Spouse: _____ Attorney: _____
Parent: _____ Employer: _____
Friend: _____ School: _____
Doctor: _____ Other: _____

(5) Check only one box indicating how long Drevna-Hudson Physical Therapy can use this authorization:

□ Disclose my information indefinitely (as long as Drevna-Hudson Physical Therapy has custody of my files)
□ Disclose my PHI for the following period beginning ___/___/_____ and ending ___/___/_____

(6) Please initial all items below indicating that you have read and understand the rights or information below:

_____ I understand that this authorization does not expire unless I have indicated an expiration date above.
_____ I understand that I can refuse to give authorization without fear of retaliation or treatment limitations.
_____ I understand that if I give authorization, I may revoke it at any time by notifying Drevna-Hudson Physical Therapy in writing at the following address 700 Eden Rd, Lancaster, PA 17601
_____ I understand that the information used/disclosed as a result of my authorization may be subject to re-disclosure. by the recipient and may not be protected by Federal privacy regulations once in the recipient's possession
_____ I understand that if Drevna-Hudson Physical Therapy requests my authorization they are required to tell me the purpose and to whom my PHI (protected health information) is being released to
_____ I understand that I will receive a copy of this authorization after I sign it and before I sign, if I request it
_____ Drevna-Hudson Physical Therapy will not be compensated for using or disclosing my PHI unless related to treatment or payment.

I understand all the provisions in this Authorization, and I wish to execute this Authorization thereby authorizing the use and/or disclosure of the information described above for the purposes described above.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED THIS AUTHORIZATION AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR THE PURPOSES SET FORTH WITHIN THIS AUTHORIZATION
You May Refuse to Sign this Authorization.

_____ **or** _____ _____
Signature of Patient **Signature of Parent or Authorized Representative (Indicate the Relationship)** **Date**

A Copy of the completed and signed Authorization Form has been Provided to the patient or representative _____Yes _____No

Signature of Authorized Practice Representative _____ Date _____