

Authorization for Use or Disclosure of Protected Health Information

I, _____
authorize Integrated Physical Therapy, their administrative and clinical staff to (check all that apply):

- use the following protected health information, and/or
 disclose the following protected health information to:

Name _____

Address _____

Phone _____

Information requested and dates of service _____

Please specify any information that is NOT to be released _____

This protected health information is being used or disclosed for the following purposes:

____ Continuing Care ____ Worker's Comp ____ Moving ____ Legal Action ____ Insurance/Payer
____ Other _____

The patient has requested this information be used and disclosed but does not wish to specify the purpose.

This authorization shall be in force and effect until _____ at which time this authorization to use or disclose this protected health information expires. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to:

Privacy Officer
Integrated Physical Therapy
130 Rock Point Dr.
Durango, CO 81301

I understand that a revocation is not effective to the extent that my provider has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim or if my authorization was required for treatment provided by participating in a research study.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that if I refuse to sign this authorization I may not be eligible for, or receive research-related treatment or treatment that I have requested for the purpose of disclosure to others.

Signature of Patient or Personal Representative Date

Print Name of Patient or Personal Representative Description of Personal Representative