Authorization to Use and Disclose Protected Health Information

Authorization to release the protected health information of:			
Patient Name:			Location:
Current Address:	City:	State:	Zip:
Social Security Number:	Phone Number:	Date of Birth:	
This authorization is to release the protected health information to:			
Individual or Healthcare Provider Name:			Patient ID:
Address:	City:	State:	Zip:
Phone Number:	Fax Number:		
This authorization is to release the protected health information from:			
McDonald Physical Therapy & Sports Rehabilitation Center 1005 Hickory Rd, South Bend, IN 46615			Phone/ Fax: (574) 233-5754/(574) 233-7406

The purpose of this use or disclosure is to:

- ☐ Personal use by patient
- ☐ Provide the requested information to the healthcare provider listed above.
- ☐ Add to the healthcare provider listed above to my record and send all future
- ☐ Release PHI to additional individuals besides patient
- ☐ Other (please specify):

Release the following information:

- ☐ Initial Evaluation
- ☐ Progress notes/ (re)certifications/ addendums
- ☐ Billing statements/ accounting information/ insurance information
- ☐ Full set of PHI records from Date: _____/_____/_____ to Date: _____/_____/_____
- ☐ Other (please specify):

Date(s) of service requested:

This authorization will expire 180 days from the date signed unless otherwise specified below (requests to add a healthcare provider to my record do not expire unless this authorization is revoked):

□ On the following date: _____

□ When the following event occurs: _____

I understand that:

˚ every effort will be made to fulfill my request as soon as possible, but it may take up to 30 days for McDonald Physical Therapy to process my request.

˚ this authorization will remain in effect until the authorization expires or I provide a written notice of revocation to McDonald Physical Therapy's private office at the address listed above. If I revoke this authorization, McDonald Physical Therapy may not be able to reverse the use and disclosure of the health information while the authorization was in effect.

˚ McDonald Physical Therapy will not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization.

˚once McDonald Physical Therapy discloses my health information by my request, it cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information.

Patient or Personal Representative Signature:	Date:
Print Personal Representatives Name (please attach applicable legal documentation)	Relationship to Patient:

Please keep a copy of this completed form for your records.