INDIVIDUAL PATIENT’S AUTHORIZATION

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE.

Psychotherapy Notes: ___ Check here if this authorization is for psychotherapy notes.
If this authorization is for psychotherapy notes, it may not authorize the use or disclosure of any other type of protected information.

1. INDIVIDUAL PATIENT (OR PERSONAL REPRESENTATIVE) CONFIRMING THE AUTHORIZATION

I give my authorization to use or disclose my protected health information as described in Section 2 below. I give my authorization voluntarily.

Individual Patient’s Name: ____

Your Address: ____

____

Your Telephone Number: ____

Your Email Address: ____

2. THE USE AND/OR DISCLOSURE AUTHORIZED

Describe in detail the protected health information you are authorizing to be used and/or disclosed (if this authorization is for psychotherapy notes, no other type of protected health information may be listed here):

PHYSICAL THERAPY

____

____

Name the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to use and/or disclose the protected health information described above.

SCHAACK PHYSICAL THERAPY/ SCHAACK PT BILLING/COLLECTION SERVICE

____

Name the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to receive and use your protected health information.

BILLING SERVICE, DOCTOR, INSURANCE COMPANY, SPOUSE, PARENT

____

Describe each purpose for which you are authorizing your protected health information to be used and/or disclosed.

TREATMENT AND BILLING

____

3. ENDING THIS AUTHORIZATION

Select one of the following two choices.

___ This authorization will stay in effect until revoked.

_X_ This authorization will end when the following event happens. The event must relate to the individual or the purpose of the authorized use and/or disclosure. Describe the event below.

WHEN NOTIFIED BY PATIENT

4. CHANGING YOUR MIND ABOUT THIS AUTHORIZATION

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer at your office. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims und the insurance policy.

5. SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF TREATMENT

I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. However, I understand that signing an authorization that permits the use and/or disclosure of my protected health information for research purposes may be a condition of my treatment if I am undergoing research-related treatment. Also, I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for disclosure to a third party. And under some circumstances, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.

6. POSSIBILITY OF REDICLOSURE

I understand that information disclosed under this authorization may be disclosed by the recipient. Federal privacy rules may not protect the privacy of my health information once the recipient rediscloses my health information.

7. INDIVIDUAL PATIENT'S SIGNATURE

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature: ____ Date: _________________

Personal Representative's Name: ____

Signature: ____

Relationship to Individual Patient: ____

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.