Patient Disclosure Authorization Form

Patient Name: ____ Date of Birth: ________________

I authorize disclosure of my protected health information only in the specific manner, for the named reason, and the specific individuals(s) described below.

Specific description of information to be used or disclosed:

☐ Only disclose information about my present medical problem

Other____

____

Reason for requested use or disclosure:

☐ Physician Request for follow-up

☐ Insurance Request

☐ Patient/Family request. If family, list names____

☐ Employment related or to substantiate a disability claim

☐ Other ____

(use additional sheet if necessary)

Office staff at this practice authorized to disclose my information (if discloser is not at this practice, ask for assistance):

Nando Addari, MSPT

This authorization will expire on the following:

☐ Date: _______________________

☐ Event (relating to patient or the purpose of the disclosure): ______________________________

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This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing to the Privacy Officer at this practice, except if this practice has taken action relying on this consent or if the authorization was obtained as a condition of obtaining insurance coverage.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use or disclosure.
- I have the right to access my protected health information to be used or disclosed.
- I will receive a copy of this completed and signed authorization form.

Signature: ____ Date: _______________________

Relationship to patient (if signed by a personal representative of patient): ______________________________