ATI PHYSICAL THERAPY

Authorization for Access, Use and/or Disclosure of Protected Health Information

CLIENT (PATIENT) INFORMATION

Last _____ First _____ MI _____

Street _____ City/State _____ Zip _____

SS# ____ - ____ - _____ Date of Birth: _____ Telephone Number: _____

SIGNATURE: _____ Date: _____

RELATIONSHIP (Choose one): ☐ Patient ☐ Legal Representative ☐ Other: _____

I hereby authorize ATI Physical Therapy to release information as indicated below to:

Name _____

Street _____ City/State _____ Zip _____

Telephone Number: _____ Fax Number: _____

Reason for the Request: _____

Disclosures for the Following Dates of Service: _____

Specific description of information to be accessed and/or disclosed:

☐ My medical records:

☐ Complete medical record (except for mental health and/or developmental disability, substance abuse, and/or HIV/AIDS-related information; must be checked separately)

☐ Only the following portions of my medical record

☐ Mental health and developmental disability records

☐ Substance abuse records

☐ HIV/AIDS-related information records

☐ Other: _____

☐ Therapy notes: Physical, Occupational, and/or Speech

☐ Social Work Notes

☐ Nursing Notes

☐ Physician Documentation

☐ My billing records

Request Access and/or Disclosure for the following dates of service: _____

I have read and understand the following statements:

- I understand this Authorization will expire 60 days after I sign this form. *Note: If authorization is for disclosure of mental health records, it must have a calendar date expiration or the information may only be **disclosed** on the current day. Note: If this authorization is for research, an expiration date is not required.*

- I understand that ATI may be allowed by law to refuse to allow access to or disclosure of all or part of my protected health information. If access or disclosure is denied or refused ATI will not release the information as requested in this Authorization, and I will be notified of the denial/refusal in writing.

- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that ATI will not condition treatment, payment, enrollment in any health plans or my eligibility for benefits if I decide not to sign this Form.

- I understand that I may revoke this Authorization at any time by notifying the ATI Compliance Officer in writing, but if I do, it will not have any effect on any actions ATI took before it received the revocation.

- I understand that there is potential for information disclosed based on this authorization to be subject to re- disclosure by the recipient and no longer be protected by the Privacy Rule.

- I understand requests may be subject to a copying fee. If sent to a care provider for continued treatment, there will be no charge.

**If this Authorization Form authorizes use and/or disclosure of psychotherapy notes it may not be used to authorize the use and/or disclosure of any other protected healthinformation.*