Choice Therapy
Physical · Occupational · Speech

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Authorization for Release of Patient Identifiable Health Information

Patient Name: _____ Medical Record Number_____

Address: _____Date of Birth_____

1. I authorize the use or disclosure of health information from _____ to _____ at (address)_____ from medical record(s) regarding all injuries, medical history, and physical condition. The purpose of this is for further medical care.
2. The type and amount of information to be used or disclosed is as follows:

a) _____Discharge Summary
b) _____Operative Reports
c) _____Consultation Reports
d) _____Pathology Reports
e) _____History and Physical Exam
f) _____X-ray Reports
g) _____Laboratory Reports
h) _____Doctors Progress Notes
i) _____EEG's, EMG's, EKG's, MRI's, CT Scans
j) _____Physical Therapy Notes
k) _____Occupational Therapy Notes
l) _____Doctor Statements
m) _____All Medical Records
n) _____Other (Specify)_____

3. I understand that the information in my health records may contain information related to AIDS (acquired immunodeficiency syndrome), HIV (human immunodeficiency virus), or sexually transmitted diseases. It may also contain information about mental health services and treatment for drug and alcohol abuse.
4. I understand that I may revoke this consent at any time and that I must do so in writing. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a clam under my policy. Unless otherwise revoked, this authorization will expire on _____.
5. I understand that authorizing this disclosure is voluntary. I can refuse to sign this authorization and still receive treatment. I understand that I may inspect or copy the information disclosed as provided in CFR 164.524. I understand that and disclosure of health information has the potential for an unauthorized redisclosure and the information may not be protected b federal confidentiality rules. I have the right to ask questions regarding this information.
6. I understand I will be given a copy of this authorization form, after signing

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient if Legal Representative Witness