

PATIENT AUTHORIZATION TO DISCLOSE
PROTECTED HEALTH INFORMATION

Please complete this form to allow us to transfer information that HIPAA regulations would not normally allow us to transfer without your authorization.

Patient name:

Patient account number:

The information covered by this authorization includes:

___ Scheduling

___ Transportation

___ Insurance

___ Treatment/care

The information described above MAY BE DISCLOSED TO:

(please check all that apply)

Doctors or health care professionals involved in my care Spouse, partner

Children, other family members Employer Attorney

Others (please list): _____

Please check all that apply:

You may call my home

You may leave a message on my home answering machine

You may leave a message with any individual at my home

You may call my cellular phone

You may leave a message on my cellular phone voicemail

You may call me at work

You may leave a message on my voicemail at work

You may leave a message with a secretary or other work associate

I understand that Chapin and Havlicek Physical Therapy will make reasonable efforts to accommodate this request. I further understand that in some emergency situations my protected health information may be released.

I understand that I have the right to revoke or terminate this authorization by submitting a written revocation to Chapin and Havlicek Physical Therapy. (see front desk for forms)

Patient Signature

Date

CHPT Staff Witness