ACROSS ALL AGES
PHYSICAL THERAPY, LLC
380 S Germantown Rd., Breese, IL 62230
Phone: 618-526-9311 ● Fax: 877-420-7862

Use & Disclosure of Information

We, Across All Ages Physical Therapy, LLC, may need to release certain protected health information (PHI) in order to provide complete, comprehensive care and to receive payment for our services. In accordance with State and Federal regulations, we request written authorization to release this information.

- I authorize the agency, the holder of medical and other information about me, to release such information and medical records concerning my illness or injury to Medicare, its intermediaries, carriers, peer review organization, insurance companies, other third party payers and their agents, and/or Medicaid for benefit and/or claim process. The agency will provide a copy of the medical records and may assess a reasonable charge in accordance with state law for such copies.
- I consent to the review of my medical records for regulatory, accrediting, academic, medical, and statistical purposes. A photocopy of the medical record may be used for these purposes. The agency is hereby released from all legal liability that may arise from the release of information for the foregoing purposed and those stated on the "Notice of Patient Information Practices".
- I understand that I will review this consent no less often than annually.

☐ I agree to allow any of my family and/or caregivers to request or receive specified protected health information (PHI) from this agency.

☐ I agree to allow the following individuals to request or receive specified protected health information (PHI) from this agency.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

☐ I object to allowing any individual, other than healthcare providers, to request or receive protected health information (PHI) from this agency.

☐ I understand that I may amend this information at any time by notifying the agency.

_____
Patient Name (Printed)

_____ _____
Patient (Parent/Legal Guardian) Signature Date