Mt Ascension Physical Therapy

Authorization for Disclosure of Individual Health Information

Patient Whose Information is to be Disclosed (please print):

Patient Name: _____ Date of Birth: _____

Street Address: _____ Daytime Telephone: _____

City: _____ State: _____ ZIP Code: _____

Person(s) or Entity(ies) to Whom Information May Be Disclosed (please print):

Name(s): _____

Street Address: _____ Daytime Telephone: _____

City: _____ State: _____ ZIP Code: _____

Information to be Disclosed by Ascension Physical Therapy (Check all that apply):

☐ Physical Therapy Records //

***Please indicate case or dates of service** (example: neck injury from 2005; right ankle injury 1/1/16-12/31/16) _____

☐ Other:

_____

(Specify other information authorized for disclosure if not listed in categories above)

Reason for disclosure (check one):

☐ At the request of the authorized individual or entity

☐ Other reason for disclosure (other than "at the request of the authorized individual or entity") (describe):

_____

Length of Time for Which This Authorization is Valid:

This authorization is valid up to 24 months (or a shorter period of time if so indicated) or for a particular event that has occurred, as stated in the authorization. If you are making this authorization for an extended period, the authorization will have to be renewed after its expiration. This authorization will remain in effect until (check one):

☐ 24 months from the date of signature of this authorization

☐ Until _____, but no longer than 24 months from the date of signature
(Month/Day/Year)

☐ Until all information relating to a certain event or injury has been provided (e.g., "Back injury from April 2009" or "formal research") (Specify event and approximate date of event):

_____

I understand this authorization is not valid without the required signature. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment with Ascension Physical Therapy. However, there may be consequences with the intended recipient of this information. I understand that the recipient of this information may possibly re-disclose the information to others without my knowledge or authorization, in which event the privacy law may no longer protect my information. I understand I have the right to revoke this authorization at any time in writing, except to the extent that Ascension Physical Therapy has already provided the information. To revoke this authorization, write to Ascension Physical Therapy, 3345 Colton Drive, Suite A, Helena, MT 59602 or call Ascension Physical Therapy at 406-513-1422.

_____ _____ _____

Print Full Name Signature Date

Relationship to patient: _____