HIPAA AUTHORIZATION FORM

I, _____, hereby authorize the use or disclosure of my protected health information as described below:

1. AUTHORIZED PERSONS TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Richard Rinehart is authorized to disclose the following protected health information to Office and Therapy Staff at iPT of Florida, Inc. of West Palm Beach, Florida 33409.

2. DESCRIPTION OF INFORMATION TO BE DISCLOSED

The health information that may be disclosed is:

Medical records
Communicable diseases (including HIV and AIDS)
Mental health records
All treatment records

All past, present, and future periods of health care information may be shared.

3. PURPOSE OF THE USE OR DISCLOSURE

The purpose of this use or disclosure is to make the patient/family/caregiver aware of the risk..

4. VALIDITY OF AUTHORIZATION FORM

This Authorization Form is valid beginning on _____ and expires The death of the patient or closure of iPT of Florida, Inc..

5. ACKNOWLEDGMENT

I understand that the information used or disclosed under this Authorization Form may be subject to re-disclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations.
I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.
I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Representative of Responsible Party:

Signed on behalf of _____

By:_____, patient's _____.

Patient/Responsible Party:

By:_____Date: _____