PHYSICAL THERAPY
at Walmart Health with HPRC

Authorization for Use/Disclosure of Protected Health Information

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Day Number: _____ Evening Number: _____

I authorize this Facility to disclose a copy of my specific protected health information described below, to be disclosed to:

Name/Facility: _____

Address: _____ City: _____

State: _____ Zip Code: _____ E-mail: _____

Telephone number: _____ Fax number: _____

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

State and federal law protect the following information. If this information applies to you, please indicate if you would like this information disclosed. (circle)

Yes No Alcohol/drug diagnosis, treatment or referral information

Yes No HIV/AIDS information

Yes No Mental Health information

Yes No Genetic testing information

Purpose for disclosure (circle): personal record Legal Insurance Continuation of care

Other (please describe) _____

Specific information to be disclosed:

_____

_____

_____

_____

Dates of treatment: from _____ to _____

Disclosure method requested:

Copy of protected health information mailed to: address above

Copy of record to be picked up; date for pick up _____

Fax a copy of record to (Healthcare provider only):

_____

E-mail (unsecured format, i.e. gmail, hotmail) _____

CD; date for pick-up or mailed to: _____

You may request that an electronic record be sent, however, be advised that unencrypted CD or email is not secure and can be opened and read by parties other than you.

By signing this authorization for;

- I understand there may be a fee associated with this request.
- I understand that I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to (Facility name) Attention: Health Information Management Department, (Facility Address). However, revocation will not have an effect on any actions taken before the revocation was received.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by federal or state laws regarding the privacy of my protected health information.
- I understand that treatment, payment, enrollment or eligibility may not be conditioned on whether I sign this authorization.
- I understand this authorization will remain in effect until _____ (date/event/condition specified by the patient). If I fail to specify an expiration date or event, this authorization will expire 12 months or period authorized under applicable state law if less, from the date on which it was signed.
- I understand I have a right to a copy of this authorization, a copy of this authorization is valid as an original.

_____ _____

Patient or Authorized representative Signature Date

_____ _____

Print Name Relationship to Patient