Speech-Language • Occupational Therapy • Physical Therapy

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

This form is used to release your Protected Health Information (PHI) as required by state and federal laws. Your authorization allows the release of your PHI to a person or organization that you choose. Your authorization is voluntary and may be revoked at any time by submitting a request in writing except to the extent that action has already been taken to comply with it.

PATIENT NAME: _____ DOB: ____/____/____

I herby authorize Beth Ingram Therapy Services to

☐ Release to: ☐ Obtain from:

_____ _____

_____ _____

_____ _____

_____ _____

The following information:

☐ Complete Records

Or Check all that apply

☐ Evaluation Reports ☐ Treatment notes ☐ Progress Summary ☐ Discharge Summary

☐ Billing Records ☐Plan of Treatment ☐ Attendance in treatment (Admission and discharge dates)

☐ Other: _____

The purpose of this information:

☐ Provide continuity of patient care ☐ Coordinate treatment ☐ Personal use ☐ Educational

☐ Attorney/Legal ☐ Other: _____

EXPIRATION

This authorization will expire on _____. ***If no date is specified, this authorization will expire twelve (12) months from the date it was signed.***

I authorize disclosure of the above protected health information to those listed above.

_____ ____/____/____

Signature of Patient/Parent/Legal Guardian* Date

*Legal Guardian Relationship to Patient: _____

Revised October 15, 2011