Speech-Language • Occupational Therapy • Physical Therapy

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME: _____ DOB: _____

This form is used to release or disclose Protected Health Information (PHI) as required by state and federal laws. Your authorization allows the release of your PHI to the individual or organization that you choose.

I authorize Beth Ingram Therapy Services to release to/or obtain Protected Health Information to/from the following:

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

☐ Complete Records: Any and all personal and protected health information.

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 release of information:

☐ Provide continuity of patient care ☐ Coordinate treatment ☐ Personal use ☐ Educational
☐ Attorney/Legal ☐ Other: _____

NOTE: This consent form allows personal and protected health information to be shared via telephone call with the individual or organization being authorized.

RIGHT TO REVOKE: 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 in response to this authorization.

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

CONSENT: I authorize the use or disclosure of personal and protected health information described above to the individual(s) or organization(s) identified above. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

_____ _____/_____/_____

Signature of Patient/Parent/Legal Guardian Date

Legal Guardian Relationship to Patient: _____