A1 PHYSICAL THERAPY CLINIC OF IRVING AT LAS COLINAS
HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

I. Individual (Name and information of person whose protected health information is being used or disclosed):

Name:____ Date of Birth:________________________

Social Security Number:_____________________

Address:__________________________________ City:________________ State:_____ ZIP:__________

Area Code & Telephone Number: ____________________________

II. Authorization and Purpose:

I request and authorize A1 Physical Therapy Clinic of Irving at Las Colinas to use or disclose my protected health information as described below. The medical information may be used by A1 Physical Therapy Clinic of Irving at Las Colinas for my rehabilitation services or consultation, billing or claims. **I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.**

____ _________ ______________
Person/Organization authorized to receive your information Relationship Purpose

____ __________ _____ _______
Address City State ZIP

III. Specific Description of Information to be Used or Disclosed *(Please Complete **Parts A and B** in this Section)*. **This Authorization CANNOT be used to disclose Psychotherapy Notes.**

A. Release of Sensitive Protected Health Information Under State Law:

You must check "yes" or "no" if you authorize the release of medical information, test results, records or communications specific to (***note: "yes" means this information is included in the categories you designate in Part B below***):

• Human Immunodeficiency Virus (HIV) or HIV/Acquired Immune Deficiency Syndrome: __ YES __ NO
• Sexually transmitted or "communicable" diseases (includes hepatitis, as well as venereal diseases)__ YES __ NO
• Drug, alcohol or substance abuse: __ YES __ NO
• Mental health or developmental disabilities (including mental retardation or similar disabilities, for example, those attributable to cerebral palsy, autism or neurological dysfunctions): __ YES __ NO
• Genetic testing: __ YES __ NO

B. Release of Protected Health Information *(check one or more)*:

Health Plan Benefit Information: Includes information contained in your benefit booklet (i.e., copayments, coinsurance, eligibility and other benefit information). __ YES __ NO
Claims: Includes information related to payment of your claims for service you received, including pertinent information located on a claim form (i.e., billed amount, general procedure descriptions claim payment or denial reasons, etc.). __ YES __ NO
Service Determination Information: Includes any information related to pre-service, concurrent and post-service decisions. __ YES __ NO
Services from Provider name: Includes information related to services rendered by a specific provider or supplier.
__ YES __ NO
Other: __ YES __ NO

IV. Expiration and Revocation:

Expiration: This authorization will expire on (must choose one):

_______One year from the date it is signed Other (insert date or event):____________________

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to A1 Physical Therapy Clinic of Irving at Las Colinas. **I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.**

V. Signature (this document must be signed by the individual, parent of minor child or the individual's personal representative)**:** I understand that this authorization is voluntary. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

_________________________ ___________________

Signature **Date: month/day/year**

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator complete the following and attach a copy of the Legal documents. You do NOT have to attach copies of these documents if they are already on file with A1 Physical Therapy of Irving at Las Colinas:

____________________________ ______________________

Personal Representative's Name **Relationship to Individual**

__________________________________ __________ ___ ______________

Personal Representative's Address **City** **State** **ZIP**

____

Personal Representative's Area Code & Telephone Number

BEFORE RETURNING YOU SHOULD KEEP A COPY FOR YOUR RECORDS BY EITHER: (1) MAKING A PHOTOCOPY OF THIS SIGNED AUTHORIZATION; OR (2) COMPLETING AND SIGNING THE DUPLICATE AUTHORIZATION FORM YOU RECEIVED OR PRINTED.

If you need assistance completing the form, please do not hesitate to ask us.