AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

NOTICE: PHOENIX Rehabilitation and Health Services, Inc. (PHX PT), and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your PHI confidential. If you have authorized the disclosure of your PHI to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

I authorize PHX PT, to release information from the record of:

Patient Name	Date of Birth	Last 4 SSN

Street Address	City	State	Zip Code

Email Address

Delivery Method: □ Email □ Fax □ Mail □ Pick up at Local Clinic_____

Please note each authorized recipient of PHI below:

To:

Facility/Person to Receive Records	Phone	Fax

Street Address	City	State	Zip Code

To:

Facility/Person to Receive Records	Phone	Fax

Street Address	City	State	Zip Code

To:

Facility/Person to Receive Records	Phone	Fax

Street Address	City	State	Zip Code

This disclosure can be used for the following purposes(s): □ Personal Use □ Legal □ Insurance □ Medical Treatment □ Medical Condition Verification □ Disability □ FMLA □ Workers' Comp □ Other:

The records are to include the following: □ Physical Therapy notes (Pre-, Post-Offer Screening, Functional Capacity Evaluation (FCE)) □ Occupational Therapy notes □ Speech Therapy notes □ Occupational Medicine notes □ Itemized Billing □ Other: Include dates:

There is no mental health, HIV or drug and alcohol information included in these records.

I understand that this Authorization is effective for a period of 90 days from the date of signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to **PHOENIX Rehabilitation and Health Services, 2000 Westinghouse Drive, Suite 200, Cranberry Twp, PA 16066**.

See the items listed on the following page for additional patient rights and responsibilities. If applicable, specify other expiration date/event here: _____

Date of Signature	**Signature of patient**	Date of Signature	**Signature of Authorized Representative**

Appropriate paperwork required

□ Parent or Legal Guardian

□ Next of Kin of Deceased

□ Power of Attorney Executor of Estate

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ORAL AUTHORIZATION (for persons physically unable to sign)

I witness that the patient understood the nature of this release and freely gave their oral authorization (Two witnesses are required).

Date Witness # 1	Date Witness # 2

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Please be aware that health care facilities are authorized by State law to charge for the reproduction of medical records and that charges may be associated with this request. Requestors may be notified in advance of the amount due for the request and records will be sent upon receipt of payment.

Additional Patient's Rights and Responsibilities:

- A disclosure statement, as required by law, will accompany all records released. Release of my records will be for the purpose stated on this form.
- Only those items checked off or listed will be released.
- Although applicable law may prohibit re-disclosure of these records, I understand that it is possible that the facility/person that receives the records may re-disclose the information, therefore (1) PRHS and its staff/employees have no responsibility or liability as a result of a redisclosure and (2) such information would no longer be protected by the Privacy Rule.
- My decision to revoke the Authorization does not apply to any release of my records that may have taken place prior to the date of my revocation of the Authorization
- My decision to revoke the Authorization may result in my insurance company not being able to pay for my medical care and I understand that I may be responsible for payment of the claim.
- PRHS, cannot require me to sign the Authorization in order to receive treatment. In accordance with State Code related to Drug and Alcohol treatment information to be released to judges, probation or parole officers, insurance company, health or hospital plan or government officials shall be restricted to the following: 1) Whether the client is or is not in treatment 2) The prognosis of the client 3) The nature of the program 4) A brief description of the progress of the client 5) A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.
- I am entitled to a copy of this completed Authorization form.