GloverTherapy.com

GLOVER PHYSICAL THERAPY and Pain Rehabilitation

Personal Treatment Specializing in Chronic Pain and Orthopedic Services.

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF HEALTH INFORMATION

Identify below, the individual whose protected health information will be disclosed:

Individuals Name	Social Security Number	Daytime Phone Number	
Mailing Address	City	State	Zip Code

Does somebody else carry your insurance? (ie. Spouse/Parent etc.) YES: ___ NO: ___

If yes:

Name of Policy Holder	Policy Holders Date of Birth	Relationship to Policy Holder

PURPOSE OF AUTHORIZATION

This authorization is required for your Health Plan to release your health information to someone other than yourself or for purposes outside the Health Plan's normal operations (treatment, payment of claims, or healthcare operations). The recipients of this authorization will rely on it to disclose your health information. Please review it carefully.

THE TYPE AND AMOUNT OF INFORMATION TO BE USED OR DISCLOSED IS AS FOLLOWS:

The complete medical record/chart of the above named patient and all materials or information including, but not limited to, all medical records, hospital records, physicians' records, surgeons' records, consultation records, operative reports, physical therapy and other therapy records; x-ray, CT scan, MRI, PET scan and reports or other psychotherapy notes, correspondence; consent for treatment; statements for services rendered; or any other materials (whether written or stored, created or maintained in any other form) relating or pertaining to this patient, including documents and records received from or that were created by another provider. This authorization shall remain in full force and effect until it **expires three years from the date set forth below**.

I understand that I have the **right to revoke this authorization** at any time. I understand that if I revoke this authorization I must do so in writing by sending or presenting my written revocation to the privacy contact of the health care provider named above. I understand that the revocation of this authorization will not apply to the extent that the health care provider has taken action in reliance thereon; or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that authorizing the disclosure of this health care information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure of the patients health information by the recipient, resulting in the health information no longer being protected by federal or state confidentiality rules.

A photocopy of this authorization is to be considered as valid as the original.

_____ Date: _____

Signature (and if appropriate, relationship to patient)

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