OPTIMUM PERFORMANCE PHYSICAL THERAPY

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Request: ____/____/_____

Address: _____
Street City State Zip Code

Date of birth: _____/_____/_____

As required by the Privacy regulations, this practice may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my patient health information to the following persons: (*you may write your doctor's name and/or family member's name).*

_____

_____

_____

_____

Patient Health Information to be disclosed: *(check all that applies)*

( ) Physical therapy reports
( ) Medical tests
( ) Others: _____

Effective dates for this authorization: _____/_____/_____ to _____/_____/_____
(you may use date of initial visit as your start date and authorization can end up to one year from start date).

_____
Signature of Patient / Authorized Representative