FIRST CHOICE PHYSICAL THERAPY
PO BOX 298658 Wasilla, AK 99629
Phone: 907-357-9755 * Fax: 907-357-9499

Authorization for Use and Disclosure of Protected Health Information (PHI)

Patient Legal Name: _____
Birthdate: _____ **Account #:** _____
Address: _____ **Phone #:** _____
City: _____ **State:** _____ **Zip Code:** _____

I hereby authorize: _____
_____

To disclose/release the Protected Health Information (PHI) of the patient listed above to:

Person/Organization:_____
_____
Address:_____
_____
Phone#: _____ **Fax #:** _____

Purpose:
Continuation of Care _____ **Insurance or Workers Comp.** _____ **Litigation** _____
Dates of Treatment: _____ **Specify Date Needed:** _____

Pertinent PHI Information:

☐ Initial Evaluation ☐ Progress Notes ☐ Daily Notes ☐ Discharge ☐ Billing Records ☐ Entire Record

ACKNOWLEDGEMENT: I request and authorize the above-named health care provider to release the information specified above to the organization, agency, or individual named on this request. I understand that the information to be released may include information regarding drug and alcohol abuse, communicable/infectious diseases, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and psychological or psychiatric conditions, if any. I understand that if the receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy regulations and may be redisclosed.

EXPIRATION: Without my express revocation, this authorization will automatically expire one year from the date hereof, unless otherwise specified: _____.

REVOCATION: I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. To revoke this authorization, I must submit a letter to the Director of Health Informat6ion Management.

OTHER CONDITIONS: A copy or facsimile of this authorization with my signature may be used with the same effectiveness as an original. I understand that:
*If I do not sign this authorization, First Choice Physical Therapy will still provide treatment and seek payment for services provided.
*Fees/Charges will comply with all laws and regulations applicable to release of information.

I authorize _____ **to pick-up my Protected Health Information.**

_____ _____ _____
Date **Signature of Patient/Patient Representative** **Relationship to Patient**

_____
Witness
If patient is unable to sign, document reason: _____
_____
_____

VERIFICATION: ☐ **Power of Attorney** ☐ **Driver's license or other appropriate ID**