EXSTROM PHYSICAL THERAPY

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Full Patient Name ______________________________ **DOB** _____/_____/_______

AUTHORIZATION

The undersigned hereby authorizes the business and employees of:
Exstrom Physical Therapy at **3818 Normal Blvd., Lincoln NE, 68506** to use and/or disclose the following approved healthcare information to the following individual/organization:

Full Name:____ Relation: ___________________________

Organization _______________________________________ Phone (_____) - _______-___________

Address ____ City _____________ State _______ Zip __________

For the purpose of ____

Beginning on (date) _____/_____/________

INFORMATION TYPES TO BE RELEASED

- ☐ All Medical and Financial Records **-OR (select below)-**
- ☐ Most recent history and SOAP Notes — Dates: From _____/_____/_____ To _____/_____/_____
- ☐ Most recent Progress/Plan of Care Notes — Dates: From _____/_____/_____ To _____/_____/_____
- ☐ Most recent discharge report
- ☐ Most recent Evaluation
- ☐ Account and Payment History
- ☐ Insurance/Worker's Comp/Medicare/ Medicaid History
- ☐ Most recent Diagnosis
- ☐ Most recent Exercises and Treatment Protocols
- ☐ Presence at the Clinic (for phone calls received, etc)
- ☐ Other (please specify) _______________________________

CONDITIONS

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

EXPIRATION/REVOCATION

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Exstrom Physical Therapy via mail, fax or hand delivery. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurers with the right to contest at claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____________________. If I fail to specify an expiration date, event or condition, this authorization will expire in 90 days. After the expiration date, we will need to obtain a new authorization from you as is required by law.

FURTHER USES AND DISCLOSURES

When we use or disclose your health information to other parties as you have instructed in this authorization, we will not have the ability to monitor whether your health information may be further used or disclosed by such parties. In such a situation, your disclosed health information may no longer be protected by federal and state privacy laws.

My signature below indicates that I have read this agreement and understand it fully.

Printed Name ______________________________ **Date** _____/_____/________

Signature ________________________________