

# Physical Therapy Services Of Morristown

## Authorization for Release of Protected Health Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

***I hereby authorize disclosure of my protected health information as follows:  
(Check all that apply)***

- Complete Medical Record for all services to include: History and Physical Exam; Progress Notes; Physician Orders; Exercise Programs, Laboratory Tests; X-ray Reports.
- Records related only to the following injury(s): \_\_\_\_\_
- Records related only to the following date(s) of service: \_\_\_\_\_
- Athletic Injury Status: (specify information) \_\_\_\_\_

***The purpose of this release of information is for:***

- Transfer of Records to another provider.
- Transfer of Records to complete health records or information at another entity or service
- Attorney
- Personal Use
- Other: \_\_\_\_\_

***I understand the following:***

(Please initial all statements)

\_\_\_\_\_ I understand that my records are protected under HIPAA/PHI regulations and the N. J. Statute NJS 26:5C-7 and 5C-8 (Patient and Physician Privilege).

\_\_\_\_\_ I understand that under the Federal Protected Health Information regulations, I have the right to review my record and request amendments where appropriate.

\_\_\_\_\_ I understand that my health information may be subject to re-disclosure and not protected by federal or state statutes (medical emergencies, reporting of communicable diseases as required under NJ Public Health Statutes, subpoenas duce tecum and government agencies upon appropriate and authorized court orders).

\_\_\_\_\_ I understand that the specific information to be disclosed in my medical record may include information regarding drug or alcohol use, counseling referrals and/or a history of testing or treatment of acquired immune deficiency syndrome (AIDS) or related conditions. (\*)

\_\_\_\_\_ I understand that I may revoke this authorization at any time by notifying Physical Therapy Services of Morristown in writing except that revocation will not cancel any action taken by Physical Therapy Services of Morristown upon the original Authorization for Release of PHI.

\_\_\_\_\_ I understand that this Authorization of Release will expire in 90 days from the date signed.

**Notice to Receiving Entities: Protected Health Information Disclosure Statement**

The information on the above patient has been disclosed to you from records protected by NJ State Statutes NJS 26:5C-7, 26:5C-8 and or federal confidentiality rules 42 CFR part 2.

Receiving entities are prohibited from further disclosure without the written consent of the above named patient. A general authorization for release is not sufficient for this purpose.

**Release of Information is to:**

Name: \_\_\_\_\_

Organization/Entity: \_\_\_\_\_

Address: \_\_\_\_\_

City: State: Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

This release will expire \_\_\_\_\_ days from the date signed. Any requests made after this time frame will require a new release. Number of days from date signed shall not to exceed 180 days.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\*(Note: A separate authorization is required for the release of Counseling Records and HIV Treatment Records)