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)