

UNIVERSITY OF SOUTH ALABAMA

COLLEGE OF ALLIED HEALTH PROFESSIONS

DEPARTMENT OF
PHYSICAL THERAPY
PHYSICAL THERAPY CLINIC

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(Mark whichever is applicable) USE OF PHI _____ DISCLOSURE OF PHI _____ OBTAINING PHI _____

USA PHYSICAL THERAPY CLINIC AUTHORIZATION FOR USE, DISCLOSURE, OBTAINING PROTECTED HEALTH INFORMATION, WHICH MAY RELATE TO PSYCHOLOGICAL, DRUG OR ALCOHOL CONDITIONS AND/OR DIAGNOSIS, TREATMENT OR CARE FOR HIV+, SEXUALLY TRANSMITTED DISEASE OR COMPLICATIONS RELATED TO SAME.

I hereby authorize **USA Physical Therapy Clinic** to use, disclose, or obtain health information from medical record of:

NAME _____

ADDRESS _____

PHONE NO. _____ DATE OF BIRTH _____ SSN _____

1. Information that is to be used, disclosed to or obtained: **ALL** (please check) or **SPECIFIC DATES** (please indicate)
- | | | |
|-------------------------|----------------------------------|---------------------------|
| Discharge summary _____ | Laboratory reports _____ | History & Physical _____ |
| X-ray reports _____ | Operative/procedure report _____ | Pathological report _____ |
| Billing reports _____ | Other (specify) _____ | |

2. Protected Health Information may be used by, disclosed to or obtained from: **(Include complete address)**
- _____
- _____
- _____

3. Purpose of Use and/or Disclosure of PHI:
- | | | |
|----------------------|-----------------------------|-----------------------|
| Attorney/legal _____ | Continued treatment _____ | Personal use _____ |
| Research _____ | Worker's compensation _____ | Other (specify) _____ |

BY PROVIDING THIS AUTHORIZATION, I UNDERSTAND AS FOLLOWS:

- I understand that such medical records may contain information concerning psychological, drug, and/or alcohol conditions, and/or diagnosis, treatment and care of sexually transmitted disease or complications related to sexually transmitted diseases, including but not limited to HIV testing and test results. I hereby authorize _____ or do not authorize _____ (*patient must initial one*) the release of such medical records pursuant to this authorization for release, and waiver of confidentiality provisions, pertaining to this release.
- I understand that the health information to be released may be subject to redisclosure by the recipient of the health information and no longer protected by the federal Privacy Rules.
- I understand that I may revoke the Authorization at any time by notifying USA Physical Therapy Clinic in writing, but if I do, it will not have any effect on uses and disclosures prior to the receipt of the revocation.
- I understand that I will receive a copy of this Authorization after I sign it.
- I understand that this Authorization will expire on _____ (date) or upon the following event (*if for research put "None" or "End of research study"*) _____

Signature of Patient

Date

Name of Patient's Representative (if applicable)

Representative's Relationship to Patient

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

AN EQUAL OPPURTUNITY/EQUAL ACCESS INSTITUTION