Authorization for release of information

Patient Name:_____ Date of Birth:_____

Person/Organization authorized to provide the information:_____
_____

Person/Organization authorized to receive the information:_____

_____

Specific description of information authorized to be release (include dates):_____

_____

_____

Purpose of Information: (if other than “at the request of” describe)

_____At the request of:_____

_____Other:_____

Expiration date for authorization:(if any) _____None_____

Statement of Authorization:
I hereby authorize the use and/or disclosure of my identifiable health information as described above. I have been informed and understand the following:

I have a right to revoke this authorization by notifying the providing person/organization in writing, and if I do revoke the authorization it will only affect release of further information. It will not apply to information already released.
I understand that there is a potential for the information authorized to be subject to disclosure by the recipient, and in some cases, will no longer be protected health information.
I understand that my healthcare will not be affected if I do not sign this authorization.

_____ _____
Signature of patient/representative Date
Relationship to Patient:_____ Copy given to patient/representative___Yes____ No

Consent For Request of Medical Information
Records/Medical Information

I have selected and hereby authorize:_____

to release photocopies of my medical record(s) and/or medical information contained therein, including AIDS/HIV test results, diagnosis, treatment and related information on:

Patients Name:_____ DOB:_____

Date of Service:_____

Release to:

Phillip J Parker, OTR
1243 N Stuart Place Rd
Harlingen, TX 78552
(956) 230-2431 (O)
(956) 306-3499 (F)

Medical information to be disclosed and/or photocopied include(s):

Entire chart	Physician dictated letter	Lab results
Progress Note	Physician orders	RadiologyResults
Financial information	Home Health	Other_____

The above information is for request of the following for this purpose only. Any other use is prohibited without specific written consent of the patient or authorized legal representative.

- Continuity of medical care
- Personal use
- Other_____

With respect to any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health and/or HIV-related condition.

_____ Yes, I consent to the release of this information _____ No, I do not consent to this release

With respect to any mental health information, which may be contained in medical records, I hereby waive his/her right to the privileges of confidently I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it and that in any event, the authorization expires automatically six months from the date signed.

The authorization expires on _____ or within 180 days of the date signed, a photo static or fax copy of this authorization shall be considered as effective and valid as the original. I understand the information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. I also understand that I may revoke this authorization at any time by signing a revocation form at the Omni Rehab office and returning it to the information privacy/security officer. I further understand that any such revocation does not apply to the extent that person authorized to sue or disclose my health information have already acted in reliance on this authorization.

_____ _____

Signature of patient/authorized legal Relationship

_____ _____

Date/Time Witness

Omni Rehab
Physical Medicine & Human Performance

Acknowledgement of Receipt of Patient Privacy Notice

The Health Insurance Portability and Accountability Act (HIPPA) is a Federal Law that give you important rights. The privacy practices of Phillip J Parker, OTR are designed to protect the privacy, use and disclosure of protected health information, and how you can get access to this information. The “Notice of Privacy Practice” was developed and is used in accordance with Federal Requirements.

If you have any questions about this notice, please contact our privacy officer:

Phillip J Parker, OTR
1243 N Stuart Place Rd
Harlingen, Texas 78550
Phone: (956) 230-2431

I have received the “Notice of Privacy Practice” as required by HIPPA Federal Law.

_____ _____
Patient/Guardian Signature Date

_____ _____
Office Representative Date

Omni Rehab

Physical Medicine & Human Performance

Last name:_____ **First Name**:_____ **Middle Name**:_____
Apellido *Nombre* *Segundo Nombre*

Date of Birth:_____ **Social Security Number**:_____
Fecha de Nacimiento *Numero de Sugero Social*

Address:_____ **City**:_____
Domicilio *Ciudad*

State:_____ **Zip**:_____ **Email:**_____
Estado *Codigo Postal* *Correo Electronico*

Home Phone:_____ **Cell phone**:_____
Telefono/hogar *Telefono Cellular*

Marital Status:
Estado Civil

☐ Single *Soltero(a)* ☐ Divorced *Divorciado(a)* ☐ Separated *Separado(a)*

☐ Married *Casado(a)* ☐ Widowed *Viudo(a)*

Method of payment

Medicare_____ Medicaid_____ Private Insurance *(Seguro)*____ Cash/Credit card_____

Primary Insurance Information

Name of Insurance:_____ Insurance Phone #:_____

Policy Number:_____ Group #:_____

Name of Insured:_____Date of Birth:_____

Social Security Number:_____

Secondary Insurance Information

Name of Insurance:_____ Insurance Phone #:_____

Policy Number:_____ Group #:_____

Name of Insured:_____Date of Birth:_____

Social Security Number:_____