Professional Rehabilitation Services
"The Outpatient Physical Therapy Specialists"

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

For New patient Chart

Patient Name: _____ Date of Birth:___/___/___

I give permission to: **Professional Rehabilitation Services** to share my health information with the designated parties below so that this person or entity may assist me with my health care issues:

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

I want PRS to share this health information: (check all boxes that apply)

☐ Complete Medical Record ☐ Billing/ Insurance Information ☐ Specific Information Only: (List below)

Other: (please specify)

_____

EXPIRATION DATE: This authorization will expire ____/____/____. If date not specified by patient, authorization will expire in (1) year.

NOTICE

• Federal law says that Professional Rehabilitation Services cannot share your health information without your permission except in certain situations. We may use and disclose medical information for treatment, payment, and health care operations. If you sign this form, you are giving PRS permission to share your health information with the person you indicate above.
• This authorization is voluntary.
• Right to revoke: If you decide you do not want PRS to share your health information any longer, you may revoke this authorization at any time. The revocation must be made in writing and is not effective in cases where the information has already been disclosed but will be effective going forward.
• Payment, enrollment, or eligibility for benefits for your health care will not be affected if you do not sign this authorization.
• I understand that if the person or organization that received this information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected.
• You have a right to receive a copy of this authorization and can contact the PRS privacy officer to get a copy if you do not have one at any time.

Signed by Patient: **The patient's parent may sign for the recipient if the recipient is a minor.**	Date:
Or Signed by Personal Representative: _____ On Behalf of: _____ (Name of patient) ***If this form is signed by the personal representative, please include a copy of the document naming the personal representative, for example, a power of attorney.**	Date: