Health Quest Therapy, Inc.
*Physical, Occupational and Pediatric Therapy*

# AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

| Patient Information | | | |
|---|---|---|---|
| Patient name | Date of Birth | Social security # | Phone # |
| | | | |
| Address | City/State/Zip | | |
| | | | |

| Request Medical Information to be Exchanged with the Following Recipients | | | |
|---|---|---|---|
| Name | Address | City/State/Zip | Phone # |
| | | | |
| | | | |
| | | | |

**The Following Records are to be released**

☐ Dr's. Referral ☐ Initial Evaluation ☐ Billing Record ☐ All Chart Notes ☐ Discharge Note
☐ Progress Notes ☐ Other: _____

**Information listed above will be disclosed for the following purposes:**

***Potential for Re-disclosure*** – Information that is disclosed under this authorization may be re-disclosed. The privacy of this information may not be protected.

***Rights of the Individual*** – You may inspect or request a copy of information that is used or disclosed under this authorization. You may refuse to sign this authorization.

***Effect of Refusing Authorization*** – If you refuse to sign this authorization, we will not deny you any treatment that is covered by your general consent to the use and disclosure of protected health information of purposes of treatment, payment, or supporting the operations. If you refuse to sign this authorization, you may not be eligible for or receive research-related treatment or treatment that you have requested for the purpose of disclosure to others including: treatment conditioned on authorization.

I also understand this consent/authorization may be revoked (in writing) at any time except to the extent already acted upon. This consent will expire in one year.

_____ _____

Patient/Guarantor (if patient is a minor) Date Relationship to Patient

Office Use: ☐ Driver's License viewed # _____ Other: _____
Released by: _____ Date: _____ Time: _____ # of pages _____

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