Medical Records
MedicalRecords@prnpt.com
Fax 760-602-4171

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

Patient Name: ____________________________ DOB:___________ MR#: ________________ Phone #_________________

Please complete Table below fully.

Organization Providing the PHI:	**Organization Receiving the PHI**	**Method of Delivery** (circle preferred method of delivery and provide contact details)
Name of Company or Treatment Location	Name of Company	Email Address
Address Line	Individual Name	Enter Email Address
City, State, ZIP Code	Address Line	Fax Number (FAX)
Phone #:	City, State, Zip Code	Enter Fax #
	Phone #	US Mail
	Fax #	See Info provided to left

If choosing *email communication*, I acknowledge and understand email communication poses potential risks that the email can be intercepted, altered, forwarded and/or read by others. **Acknowledge by providing your initials and date:** _________________

Reason for Disclosure: Specific description of information including date(s)/purpose: (For example, Social Security Disability, Attorney, Workers Compensation, Continuation of Care, Insurance, Short & Long Term Disability, Patient Request).

____

____

*(**Note**: "at the request of the individual" is a sufficient description of the purpose when the patient initiates the authorization and elects not to provide a statement of the purpose.)*

Dates of Service: (Check one)

[___] Copy of all my medical records for all dates of service.

[___] Copy of my medical records for services from ________________________ to _________________________.
(Start Date) (End Date)

Information to be Disclosed: (Please check the boxes that apply)

[___] All Medical Records [___] Initial Evaluation [___] Discharge Summary [___] Daily Notes
[___] Billing and Claims [___] Progress Notes [___] FCE Report [___] Home Exercise Program
[___] Exercise Flow Sheet

[___] Other____

Must be completed for all authorizations:

To the extent any of the following information is contained in my medical records being released, I specifically authorize the release of such information for the purposes indicated above by initialing before each category:

Initials: ______ HIV/AIDS testing, test results, treatment and related information including high risk behavior documented;

Initials: ______ Drug and/or alcohol diagnosis, treatment, test results and reports and referral Information;

Initials: ______ Mental Health treatment information, test results and reports including psychological and psychiatric studies, reports, evaluations and referral information.

I understand that I have the right to refuse to sign this form and my refusal will not result in the physician conditioning the provision of Healthcare with two exceptions:

1. Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research-related treatment.

2. Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party. **Patient initials:** ____________

Authorization Expiration:
I understand that this authorization will expire on the following date_____/______/______(DD/MM/YR).

I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing at Physical Rehabilitation Network 5962 La Place Ct. Ste 170, Carlsbad, CA 92008 Fax 760-602-4171. The revocation will only be effective from the date it is received in this office and will not apply retroactively. If no date is indicated, this authorization will expire one (1) year from the date signed.

Copying Fees:
I understand a cost may be associated with processing copies of my medical records.

______________________________	______________________________
Signature of Patient/Patient's Representative	Printed Name of Patient/Patient's Representative and relationship to Patient
______________________________	______________________________
Date	Telephone Number
______________________________	______________________________
Signature of Witness	Printed Name of Witness
______________________________	______________________________
Date	Telephone Number