



mti physical therapy

MANUAL THERAPY • ORTHOPEDICS • SPORTS

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION (PHI)

Please read all information and instructions before completing and signing the authorization form

Patient's Name _____ Birth date _____
(please print) LAST FIRST MI

Are medical records filed under another name? _____ Phone number _____

Recipient Name: _____
Address: _____
Phone Number: _____
Email Address: _____

I AUTHORIZE THE RECIPIENT ABOVE TO USE OR DISCLOSE THE FOLLOWING HEALTH INFORMATION:

- Only information related to (specify) _____
- Only the period of events from _____ to _____
- Other (specify) (Scheduling, Billing, etc.) _____
- Entire Record

THE PURPOSE OF THIS AUTHORIZATION IS (check all that apply):

- General Purpose. At my request
- Treatment, Payment or Other Healthcare Operations
- Attorney
- School
- Employer
- Financial Institution
- Other (specify): _____

This authorization expires _____ (date or event). If there is no expiration date given, this authorization will expire one year from the date of signature

I understand that I have the right to withdraw this authorization at any time, except for action already taken, and that such revocation must be in writing to MTI Physical Therapy. I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards. **I understand that I do not have to sign this authorization in order to receive Health Care treatment.** I further understand that if I request records for personal use, or for parties not involved in my health care, there may be a charge.

Patient signature _____ **Date** _____

Parent or Legal Guardian Signature _____ **Date** _____

Relationship to patient, if other than patient _____

Please attach Legal Documentation if you are the Legal Guardian, Power of Attorney or Executor of Estate