UNIVERSITY OF SOUTH ALABAMA

COLLEGE OF ALLIED HEALTH PROFESSIONS

DEPARTMENT OF
PHYSICAL THERAPY
PHYSICAL THERAPY CLINIC

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(Mark whichever is applicable) **USE OF PHI** ◉ **DISCLOSURE OF PHI** ○ **OBTAINING PHI** ○

USA PHYSICAL THERAPY CLINIC AUTHORIZATION FOR USE, DISCLOSURE, OBTAINING PROTECTED HEALTH INFORMAITON, WHICH MAY RELATE TO PSYCHOLOGICAL, DRUG OR ALCOHOL CONDITIONS AND/OR DIAGNOSIS, TREATMENT OR CARE FOR HIV+, SEXUALLY TRANSMITTED DISEASE OR COMPLICATIONS RELATED TO SAME.

I hereby authorize **USA Physical Therapy Clinic** to use, disclose, or obtain health information from medical record of:
NAME _____
ADDRESS _____
PHONE NO. _____ DATE OF BIRTH _____ SSN _____

1. Information that is to be used, disclosed to or obtained: **ALL** (please check) or **SPECIFIC DATES** (please indicate)

☐ Discharge summary _____	☐ Laboratory reports _____	☐ History & Physical _____
☐ X-ray reports _____	☐ Operative/procedure report _____	☐ Pathological report _____
☐ Billing reports _____	☐ Other (specify) _____	

2. Protected Health Information may be used by, disclosed to or obtained from: (**Include complete address**)
   _____
   _____
   _____

3. Purpose of Use and/or Disclosure of PHI:

☐ Attorney/legal	☐ Continued treatment	☐ Personal use
☐ Research	☐ Worker's compensation	☐ Other (specify) _____

BY PROVIDING THIS AUTHORIZATION, I UNDERSTAND AS FOLLOWS:

1. I understand that such medical records may contain information concerning psychological, drug, and/or alcohol conditions, and/or diagnosis, treatment and care of sexually transmitted disease or complications related to sexually transmitted diseases, including but not limited to HIV testing and test results. I hereby authorize _____ or do not authorize _____ (*patient must initial one*) the release of such medical records pursuant to this authorization for release, and waiver of confidentiality provisions, pertaining to this release.
2. I understand that the health information to be released may be subject to redisclosure by the recipient of the health information and no longer protected by the federal Privacy Rules.
3. I understand that I may revoke the Authorization at any time by notifying USA Physical Therapy Clinic in writing, but if I do, it will not have any effect on uses and disclosures prior to the receipt of the revocation.
4. I understand that I will receive a copy of this Authorization after I sign it.
5. I understand that this Authorization will expire on _____ (date) or upon the following event (*if for research put "None" or "End of research study"*) _____

_____ _____
Signature of Patient Date

_____ _____
Name of Patient's Representative (if applicable) Representative's Relationship to Patient