AARON D. ANDERS
PHYSICAL THERAPY

Authorization for Release of Protected Health Information or Treatment Records

Last Name:_____ First:_____ Middle:_____
Other Names Used:_____ Date of Birth:_____

I _____ give my permission to :
_Aaron D. Anders Physical Therapy_____
Name of Physician, Provider, and/or Department/Clinic

To release information regarding appointment dates/times and my protected health information, including but not limited to insurance, address, phone number, test results, health care information to the following:

Name of Person: _____ Name of Person:_____

Relationship to Patient:_____ Relationship to Patient:_____

Exceptions:_____ Exceptions:_____

I understand that:

- I may revoke this Authorization at any time, in writing. My revocation will not apply to information already retained, used or disclosed in response to this Authorization. Unless revoked, the automatic expiration date will be 12 months from the date of the signature.
- Unless the purpose of this Authorization is to determine payment of a claim or benefits, the provision of treatment or payment for my care may not be conditioned upon my signing of this Authorization.
- **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR A NONCOMMUNICABLE DISEASE.**
- The information authorized for verbal release may include protected health information related to mental health. Release of mental health records or psychotherapy notes may require consent of the treating provider or a court order.
- The information authorized for verbal release may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules _42 CFR Part @). The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below I specifically authorize any such records included in my health information to be released.

_____ _____ _____
Signature of patient, Parent, or Legally Authorized Representative | Relationship to Patient | Date