

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize **Vermilion Physical Therapy** to use or disclose the following protected health information (PHI) from the medical records of the patient below to:

REQUESTOR: Vermilion Physical Therapy
2626 North Drive
Abbeville, LA 70510
(337) 893-4500

Patient Name: _____ Date of Birth: _____ SSN: _____

Address: _____ City: _____ ST: _____ Zip: _____

Disclose the following protected health information for treatment dates: _____ to _____.

| | | | |
|--------------------|--------------------|-------------------|----------------|
| Abstract/Pertinent | History & Physical | Discharge Summary | Consult |
| Operative Report | Progress Notes | Physician Orders | Nurses' Notes |
| ER Reports | Lab Results | X-ray reports | Correspondence |
| Films | Reports | Bills | Entire Chart |
| Other Specified: | _____ | | |
| | _____ | | |

The above information is disclosed for the following purposes:

Medical Care Legal Insurance Personal

I understand I may revoke this authorization at any time by requesting such of the above referenced hospital/physician practice in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

I understand that the provision of medical services and the treatment of my injuries are not conditioned on my agreeing to sign this authorization to disclose protected health information. I acknowledge, and hereby consent to such, that the released information may contain alcohol and drug abuse, psychiatric, HIV, or genetic information. _____ (Initials)

This authorization expires on the following date: two years from the date below.

I have read the above and authorize the disclosure of the protected health information as stated:

Signature of Patient

Date

Signature of Legal Representative

Date