# LHM Physical Therapy Institute (LHMPTI)
# Authorization to Release Protected Health Information

## Patient Information

| Last Name | First Name | M.I. | Date of Birth |
|---|---|---|---|
| Street Address | City | State | ZIP |
| Phone Number | Email Address | LHM Medical Record Number *(LHMPTI use only)* | |

## HIPAA Authorization

Information to be provided to:

| Name of Individual or Entity | | |
|---|---|---|
| Street Address | | City/State/ZIP |
| Phone Number | Fax Number | Email Address |

**Purpose of the authorization:** □ At my request □ Sharing with other healthcare provider □ Legal

□ Other _____

**Information authorized to be released:** □ Entire medical record □ Other (specify) _____

_____

**Covering the period(s) of care:** □ All episodes of care □ List applicable dates of treatment _____

**Format of records:** □ Paper copy □ Electronic copy **Manner of delivery**: □ Pick up □ Mail □ Fax □ Email

**Special Records:** I understand that information related to my diagnosis or treatment for AIDS/HIV, psychiatric care and treatment, treatment for drug and alcohol abuse may be released as part of my health information. Please check appropriate box(es) below.

**AIDS/HIV Information:** □ Yes, disclose □ No, do not disclose or does not apply
**Psychiatric Care/Treatment:** □ Yes, disclose □ No, do not disclose or does not apply
**Treatment for Drug or Alcohol Use/Abuse:** □ Yes, disclose □ No, do not disclose or does not apply

## Authorization of HIPAA Disclosure

I understand that this authorization will automatically expire one year after the date of the signature below unless an earlier date is inserted here: _____. I understand that I may revoke this authorization at any time by sending a written request to LHMPTI, but that the revocation will not apply to information that has already been released in accordance with this authorization. LHMPTI will not condition my treatment on whether or not I sign this authorization. By signing this form, I understand that I am authorizing LHMPTI to release information as described above. I understand that once LHMPTI releases the information, it is possible that the recipient might redisclose the information such that it is no longer protected by the Privacy Rule, 45 CFR Part 164, Subpart E. I understand that fees may be associated with this request.

| Signature of Patient or Personal Representative | Print Name | Date |
|---|---|---|
| Relationship of Personal Representative to Patient | | Date |
| If Authorization is signed by someone other than the patient, please state reason | | |