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|  | Dr. Caitlin Ayres, PT, DPT, CFC |

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# AUTHORIZATION TO RELEASE PROTECTED HEALTHCARE INFORMATION

The Health Insurance Portability and Accountability Act (HIPAA) entitles you to rights that include restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately for your services at the time of service. By paying for your services at the time of service, we assume you are exercising this right to privacy and we will not disclose your medical records to any third party, including your health insurance carrier or Medicare. If you want your records disclosed to any third party in the future, you will need to obtain and sign this Authorization to Release Protected Healthcare Information form before we will disclose your health information. You also have the right to not release any information, and do not have to sign this form if you so choose.

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| Patient’s Name:  | Date of Birth: [DOB] |
| Previous Name: (if applicable)  | Social Security #: [SSN] |
| I request and authorize HouseCall Head and Neck Physiotherapy to release healthcare information of the patient named above to: | Spouse:Employer:Parent:Attorney:School:Friend:Other: |

This request and authorization applies to:



This applies to certain portions of your treatment on a specific treatment date. You will notify HCHN of which dates are to be released if you elect this option. Please initial below on which items you would like to be included.

Dates of Service:

Evaluation \_\_\_\_\_ Attendance \_\_\_\_\_\_ Correspondence regarding physical therapy treatments \_\_\_\_\_
Past Medical History \_\_\_\_\_ Treatments \_\_\_\_\_



All healthcare information means the individual(s) you have released to receive healthcare information are privy to any information you provide regarding your past medical and surgical history, current treatment, treatment dates, and current condition.

If you selected other, please outline what information you would like to be released:

Please initial next to how long you would like for this authorization to stand:

\_\_\_\_\_\_\_ Indefinitely

\_\_\_\_\_\_\_ From \_\_\_/\_\_\_/\_\_\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_\_ only

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand that I may elect to refuse to sign this authorization without retaliation or adverse effect on my treatments. I may also rescind this authorization at any time by notifying HCHNP in writing. Once I authorize the individuals outlined above to receive my PHI (protected health information), I understand that HCHN cannot guarantee protection by the individual or organization from re-disclosure and may not be protected by federal privacy regulations. I understand that should HCHN need to disclose information to any of the individuals or organizations above, it is required to tell me to whom the information was provided and for what purpose. I am entitled to a copy of this release after it is signed should I request it. HCHN will not receive compensation for using or disclosing my PHI unless related to treatment or payment procedures outside of specific permission provided by me following full disclosure of purpose and intent.

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| Patient Signature: |  | Date signed: [Date] |

### THIS AUTHORIZATION DOES NOT EXPIRE UNLESS DESIGNATED ABOVE.