AUTHORIZATION FOR UTILIZATION/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

1. INDIVIDUAL PATIENT (OR PERSONAL REPRESENTATIVE) CONFIRMING THE AUTHORIZATION

Name: _____

2. THE USE AND/OR DISCLOSURE AUTHORIZED

What protected health information (PHI) will be used and/or disclosed?

My physical therapy prescription, my insurance authorization form(s), physical therapy evaluation report, progress reports, daily notes and itemized statements of my account.

Who am I authorizing to use, disclose or receive this information?

Atlantic Physical Therapy clinical and administrative staff, Med-Systems Associates (the billing agent for Atlantic P.T.), my referring physician and claims personnel representing my insurance carrier and/or other third party payers related to my claim for coverage under my insurance policy (or policies).

What purposes am I authorizing this for?

The information will be used to assist my physical therapy provider in rendering my care or in obtaining reimbursement from my insurance carrier or other responsible party for services provided.

3. ENDING THE AUTHORIZATION

The authorization will end when I have concluded my physical therapy services for my current problem/diagnosis and reimbursement efforts have been completed.

4. CHANGING YOUR MIND

I understand that I have the right to revoke this authorization at any time by giving written notice to Atlantic Physical Therapy. I understand that it is not possible for Atlantic Physical Therapy to reverse authorized utilization of disclosures of my protected health information (PHI) that preceded the revocation. Atlantic Physical Therapy will take no further such actions unless I complete a new authorization.

5. SIGNING THIS AUTHORIZATION IS NOT REQUIRED FOR TREATMENT

I understand that under most circumstances my authorization is not required as a condition for my treatment. However, lack of authorization will make it necessary for me to file my own insurance claims and all services must be paid in full each visit. I also understand that my physical therapist will be prohibited for communicating protected health information (PHI) to my physician, my insurance company and other parties listed in section 2.

6. SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

I have reviewed the provisions of this authorization and agree to allow my protected health information (PHI) to be used for the purpose described.

_____ _____

SIGNATURE DATE