



Authorization for Release of Information

I hereby authorize the use or disclosure of my health information as described below.

I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

Patient Name: _____ **DOB:** _____ **Case#:** _____

Organization Providing the PHI:	Organization Receiving the PHI:
Physical Therapy at Thrive, LLC	Name of Company
2302 N Bogus Basin Rd, Suite C	Address Line
Boise, ID 83702	City, State, ZIP Code

Reason for Disclosure: Specific description of information (including date(s)/purpose):

(Note: "at the request of the individual" is a sufficient description of the purpose when the patient initiates the authorization and elects not to provide a statement of the purpose.)

Information Disclosed: Please check the boxes that apply

- Copy of clinic notes
- Copy of discharge summary
- Copy of all records
- Other _____

Must be completed for all authorization

I understand that I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of Healthcare with two exceptions:

1. Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research-related treatment.
2. Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party.

Patient initials: _____

I understand that this authorization will expire on the following date _____ / _____ / _____ (DD/MM/YR).

I understand that I may revoke this authorization at any time by notifying the health care provider in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively.

Signature of Patient/Patient's Representative

Printed Name of Patient/Patient's Representative

Date

Telephone Number

Signature of Witness

Printed Name of Witness

Date

Telephone Number