RADICAL RECOVERY & PERFORMANCE

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for use or disclosure of Protected Health Information

Authorization – I authorize Radical Recovery & Performance to use and discuss the protected health information to referring doctor or physician if needed.

Effective Period – This authorization for release of information covers the period of care from start of physical therapy to your last day of physical therapy.

Extent of Authorization – I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse) to Radical Recovery & Performance as it relates to my treatment.

The medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance upon my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient or Guardian Signature _____ Date _____

Printed Name _____