Cottage Grove Physical Therapy

**AUTHORIZATION TO USE AND DISCLOSE PATIENT INFORMATION**

As a patient of Cottage Grove PT Services, you have the right to know how we may use and disclose information about you. Information about our disclosures is provided in our Notice of Patient Privacy Practices, and a copy of this notice has been provided to you. You have the right to review our notice before signing this form.

You should read our Notice carefully before signing this form. As our Notice of Privacy Practices explains, we need your authorization to use or disclose information about you for any purpose other than treatment, payment or normal healthcare operations.

1. I authorize the use and disclosure of my protected health information for the following purpose(s): _____
   _____
2. By initialing and signing below, I authorize the use and disclosure of the following types of protected health information that may pertain to any health care I have received to date: *(please initial the category of information you wish to authorize use and disclosure)*
   - ✕ My entire medical record _____
   - ✕ Information related to my physical therapy referral, diagnosis, treatment, and billing _____
   - ✕ Other _____ (please specify)_____
3. I authorize my protected health information to be disclosed to: _____
   _____
   _____
4. **I have been told that information otherwise protected by law and disclosed under this authorization may be subject to re-disclosure, and my no longer be protected by law, including but not limited to privacy regulations issued by the United States Department of Health and Human Services.**
5. I agree that this authorization for use and disclosure of my identifiable health information will be effective from the date I sign this document for 180 days or at the end of the period reasonable needed to complete the authorized disclosure or until I revoke this authorization. I understand that I may revoke this authorization at any time by giving Cottage Grove PT Services notice in writing. I also understand that treatment, payment, enrollment in a health plan, or eligibility for certain health benefits cannot be conditioned on my providing this authorization.

By signing below, I agree that my protected health information may be used or disclosed as described above.

Printed Name of Patient: _____

_____

Signature of Patient or Legally Authorized Representative Date

_____

Relationship of Representative Authority

_____

Expiration date of Authorization