Personalized Therapy, LLC

Occupational & Physical Therapy for Children & Adults

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Client Name: ____

1. Person giving this authorization:

   Name: ____

   Address: ____

   Phone: ____

   DOB: ____________________ Relationship to Client: ____________________

2. Entity Authorized to release PHI:

   Personalized Therapy, LLC; 22593 Three Notch Road, California, MD 20619

3. Entity Authorized to receive PHI:

   Name: ____

   Address: ____

4. Specific and meaningful description of the PHI disclosed:

   ____

5. Reason for disclosure of PHI:

   ____

6. Expiration date: ____________________
7. Revocation: This authorization can be revoked at anytime by the person giving it by providing a signed revocation to the entity authorized to release PHI. Revocation will not apply retroactively to PHI already released in reliance on this authorization.
8. Re-disclosure: This authorization is given with the understanding that all or some of the PHI provided may or will be re-disclosed to organizations which, and person who, may not be subject to federal and state PHI privacy laws and therefore that re-disclosure by these organizations or people may not be protected by such laws.
9. Duplicates: A photocopied, faxed, or electronic duplicate of this authorization is as valid as an original.

Signature: ______________________________ Date: ____________________