Pediatric Therapy Link of North Alabama, LLC
97 Hughes Rd, Suite H; Madison, AL 35758

HIPAA AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Social Security Number: _____

Pediatric Therapy Link of North Alabama, LLC is authorized to *release/receive* medical information as designated by client.

The disclosure is for the purpose of therapy consulting and is at the request of the above named patient. In addition to the insurance company and referring physician, these records will only be released/received to those named by the client:

1_____
2_____
3_____

Please ***check*** off the type and amount of information to be used or disclosed:

☐ Patient Progress Notes and Intake Records
☐ History, Physical and Physician Progress Notes
☐ Medication Records
☐ Psychotherapy Records
☐ Laboratory Results
☐ X-Ray and Imaging Reports
☐ Consultation Reports
☐ Entire Medical Records
☐ Other: _____

I hereby authorize the use or disclosure of information about the above named patient and I understand that:

☐ I may refuse to sign the authorization.
☐ I have the right to revoke this authorization in writing.
☐ Any revocation will be effective only to the extent that action has not been taken in reliance on my prior authorization.
☐ Unless I revoke this authorization, it will expire on the following date: _____ or on the following event or condition: _____ If I do not specify an expiration date, event or condition, this authorization will expire in six months.
☐ By signing below, I recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure.
☐ Treatment or payment will not be based on my signing this authorization.
☐ I will receive a copy of this authorization.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Relationship of Personal Representative to the Patient Signature of Witness

Revised July 2013