performancehealth
SPINE & SPORT THERAPY

HIPAA RELEASE OF INFORMATION AUTHORIZATION FORM

1. Please complete this entire form.
2. Pursuant to the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and Subparts A and E of Part 164.

I hereby authorize the disclosure of information from health records of:

Patient Name:	Patient DOB:
Address:	City, State, Zip:
Primary Phone:	Alternate Phone:

Performance Health may discuss my records with:

Name:
Address:
Phone & Fax:

Information to disclose:

☐ Treatment Notes/Plans ☐ Lab/MRI/X-Ray Reports ☐ All Records

**Note: If these records contain any information from previous providers about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are authorizing disclosure of this information.*

This authorization for release of information covers the period of healthcare from:

☐ _____ to _____ **OR** ☐ All past, present, and future periods.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

This authorization expires: ☐ One (1) Year from today's date **OR**: ☐ Upon written notice

_____ _____

Signature of patient or authorized representative Date

_____ _____

Printed name of patient or representative Relationship to Patient

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