PAIR & MAROTTA
PHYSICAL THERAPY

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION

NAME OF PATIENT: ______________________________

I hereby authorize Pair & Marotta Physical Therapy to:

☐ Obtain all health records from: ______________________________
(only check this box if Pair & Marotta PT is receiving information from another source)

☐ Release all health information pertaining to medical history, physical condition, service rendered, and treatment received to:

____
Persons/Organizations authorized to receive the information

____
Address – street, city, state, zip code

The purpose of use or disclosure: ☐ Patient request

☐ Other______________________

____

Limitations, if any: ______________________________

____

____

Expiration: This authorization expires on (*date*) ______________________

My Rights:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. (1)
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so in writing (2) and submit it to the following address:______________________________

  ____

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon authorization.

- I have a right to receive a copy of this authorization. (3)
- Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by

California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

Patient Name: ______________________ Date of Birth: ________________

Social Security Number: ______________ Phone Number: ______________
(optional)

Address: __________________________ Fax: _______________________

Signature: ____
(patient or legal representative)

Date: _________________Time: ______________________

If signed by a person other than the patient, indicate relationship: _____________

Print Name: ____
(legal representative)

1. If any of the HIPAA recognized exceptions to this statement apply, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party, Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.
2. Patients of federally assisted substance abuse programs and patients whose records are covered by LPS may revoke an authorization verbally.
3. Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures (45 CFR section164.508).

5337 Truxtun Avenue
Bakersfield, CA. 93309

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