ADVANCED
REHABILITATION SERVICES

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date**: _____

SSN: _____ **Date of Birth**: _____ **Phone Number**: _____

Release To:
_____
_____
_____
_____

Disclosure Method:
_____Mail
_____Fax: _____
_____Pick Up

Purpose of Disclosure: _____

Information Requested:
_____ Copy of ALL Medical Records
_____ Copy of all Billing Records
_____ Copy of Specific Records:
_____

Pertinent Dates:
_____ All Treatment Dates
_____ Specific Dates
From: _____to_____

RIGHT OF REVOCATION/EXPIRATION: I understand that this authorization may be revoked by me at any time, provided that I do so in writing and deliver it to this provider. This revocation will not apply to records or information that has already been provided. Unless earlier revoked, this authorization will expire **one (1) year** after the date of this release.

PATIENT RIGHTS: I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I further understand that I have the right to inspect or ament my medical records as provided in 45 CFR 164.526; and I have the right to an accounting of the use and disclosure of my health information to any third party as provided in CFR 164.528.

DISCLOSURE: I understand that if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPAA privacy regulations.

I AUTHORIZE ADVANCED REHABILITION SERVICES TO RELEASE THE ABOVE-NOTED INFORMATION TO THE SPECIFIED RECIPIENT.

_____ _____
Signature of Patient or Legal Representative/Guardian Date

_____
Relationship to Patient if Legal Representative/Guardian