Authorization to use or disclose Protected Health Information

Patient Name: _____DOB: _____

Address: _____

Date of Request: _____

As required by the Privacy Regulations, this practice may not use or disclose your protected health information except as provided in our Notice of Privacy Practice with out your authorization.

I hereby authorize RightStart Therapy Services, Inc. at 2336 Wisteria Drive Ste. 240 Snellville, GA 30078 to use or disclose my Protected Health Information to the following person(s), entity(s), or business associates of this office: _____

Name of business Phone #:

_____

Address Fax #:

Patient Health Information authorized to be disclosed.

All medical records pertaining to speech-language therapy provided by RightStart Therapy Services, Inc.

For the specific purpose of (describe in detail)

Coordination of care._____

_____

Effective dates for this authorization: _____/_____/_____ through _____/_____/_____. This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reason beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending a written note to this office and that revocation will not affect this offices previous release on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Protected Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____

Signature of patient or patients authorized representative Date

If not the patient, your relationship to patient: _____

_____ _____

Authorized signature of facility Date