



Compound Authorization for Release of Information

This form is necessary to allow us to communicate with you and others that may be involved in your care. To fill it out, please fill in all blanks and checkboxes as appropriate, allowing us to speak with other professionals regarding your care. If you do not fill in blanks as specified – we cannot legally speak to anyone regarding your care, including family members etc.

Name of Patient _____ Date of Birth _____

Elite Physical Therapy is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	Description of information to be released. Check each that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Voice Mail – Home # _____ <input type="checkbox"/> Voice Mail – Cell # _____ <input type="checkbox"/> Voice Mail – Work # _____	<input type="checkbox"/> Appointment Information <input type="checkbox"/> Financial Information <input type="checkbox"/> Medical Information
<input type="checkbox"/> Other _____	<input type="checkbox"/> Appointment Information <input type="checkbox"/> Financial Information <input type="checkbox"/> Medical Information

The **purpose** of this authorization is to meet the patient's request for information disclosures and uses, and will be enforced until revoked by patient. This practice will verify the identity of any entity requesting protected health information using patient's date of birth.

Rights of the Patient

- I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Signature of Patient or Personal Representative Date _____

Description of Personal Representative's Authority (attach necessary documentation)

Office use only:

Receiving Employee: _____

Date received: _____

Copy given to patient if requested