



Worker's Compensation Compound Authorization for Release of Information

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"/> Employer	<input type="checkbox"/> Written and verbal Medical Information <input type="checkbox"/> Appointment Information <input type="checkbox"/> Financial information
<input type="checkbox"/> Employer's Attorney	<input type="checkbox"/> Written and verbal Medical Information <input type="checkbox"/> Appointment Information <input type="checkbox"/> Financial information
<input type="checkbox"/> Personal Attorney Name: _____	<input type="checkbox"/> Written and verbal Medical Information <input type="checkbox"/> Appointment Information <input type="checkbox"/> Financial 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.

_____ Date _____

Signature of Patient or Personal Representative

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

Office use only:

Receiving Employee: _____

Date received: _____

Copy given to patient if requested