PULSENYC PHYSICAL THERAPY

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BRINGING MOTION TO YOUR LIFE, AND LIFE TO YOUR MOTION

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information

Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164

I authorize Pulse NYC Physical Therapy to use and disclose my protected health information. This authorization for release of information covers all past, present, and future healthcare periods.

1. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse.
2. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
3. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
4. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
5. By the law, consent is not required to discuss your medical treatment with your other doctors of health care providers. None is required in the course of carrying out health care operations such as communication with your insurance carrier for payment related issues or incidental uses such as announcing a name in a waiting room or the use of sign-in sheets. Medical information about you may be used for research and public health uses as long as you are not individually identified.
6. This office has protected you in that we do not believe in releasing specific information about you to any business or government entity without your written consent. Specific authorization is required to disclose protected information in a non-routine circumstance.
7. Portions of this notice may be modified as long as you are notified.
8. The law requires you acknowledge receipt of this notice.

Signature _____ Date_____

Print name and relationship to patient_____