PHYSICAL THERAPY PROFESSIONALS, P.C.

LAKEVILLE
3506 Thomas Dr., Lakeville, NY 14480
(585) 346-0060 Fax (585) 346-0108

CALEDONIA/NEW YORK FITNESS
3163 State St. (Rt. 5), Caledonia, NY 14423
(585) 538-9460 Fax (585) 346-0108

MT. MORRIS/PAT'S CLUB
66 Stanley St., Mt. Morris, NY 14510
(585) 658-9280 Fax (585) 346-0108

AUTHORIZATION FOR USE AND DISCLOSURE OF PRIVATE HEALTH INFORMATION

PATIENT NAME: ____

Hereby gives Physical Therapy Professionals, P.C. my consent to inform my case worker/manager, insurance company, and doctor's office of my physical therapy progress and share protected health information for billing purposes. This includes phone conversations, faxes, progress reports, and doctor's prescriptions.

This authorization is effective through ______________________________ unless revoked or terminated earlier by the patient or the patient's personal representative.

This authorization is effective for the following diagnosis(es):
____

Additionally, Physical Therapy Professionals, P.C. may speak to the following regarding my care:
Name ____
Relationship ____
Name ____
Relationship ____
Name ____
Relationship ____

The above authorization may include notes/records and/or discussion of such. Information may include patient progress, appointment times, scheduled appointment dates, etc.

DO NOT release my information to the following: ____

I authorize Physical Therapy Professionals, P.C. to leave a detailed message if necessary on my voice mail, answering machine, or with an individual. YES _____ NO _____

I have the right to revoke this authorization at any time by sending written notification to Physical Therapy Professionals, P.C. at the above address. I understand that a revocation is not effective to the extent that Physical Therapy Professionals, P.C. has relied on the use or disclosure of the protected health information. I also have the right to inspect or copy the protected health information to be used or disclosed as permitted under Federal Law (or State Law to the extent the State Law provides greater access rights).

Signed ____

Date ________________________________