Functional Therapeutics

Occupational Therapy & Elder Care

Request for Protected Health Information / Patient Authorization for Release of Records

Patient Name: ____ S.S. # _______________________

Date of Birth _____________________ Patient Phone Number(s): ____________________________________

PERSON(S)/ORGANIZATION(S) AUTHORIZED TO MAKE DISCLOSURE:

Functtional Therapeutics
4 Northcrest Road
Weaverville, NC 28787

RELEASE INFORMATION TO: (recipient of disclosure)
Name: ____
Address: ______________________________________
Apt, Suite or PO #: _____________________________
City, State, and Zip: ____________________________
Phone: _______________________________________
Fax: ____

TREATMENT DATES TO BE DISCLOSED: ____
PURPOSE OF THE DISCLOSURE: ___Insurance ___Legal ___Continuing Care ___Personal
___Other (specify) ________________

SPECIFIC DESCRIPTION OF THE INFORMATION TO BE DISCLOSED:
Rehabilitation/Therapy Notes___ Cognitive Testing___ Radiology/Medical Testing Results ___
Other____________________

SPECIFIC INFORMATION TO NOT BE DISCLOSED: ____
I understand that the purpose of this authorization is for the use and/or disclosure of my protected health information (PHI) and that it may contain information that is protected under state laws and federal regulations. I understand that one the above information is disclosed it may be subject to re-disclosure and will no longer be protected by Privacy Protection Rules. I understand that I have the right to revoke this authorization at any time and that my revocation must be submitted to Functional Therapeutics. I understand that my revocation is not effective to the extent that the persons or organizations in which I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to receive treatment, payment enrollment, or eligibility for benefits. I understand that I will be given a copy of this authorization upon my signature.

I hereby authorize Functional Therapeutics to disclose/release medical records and other information obtained in the course of my diagnosis and/or treatment. I agree to pay copy charges if applicable.

I hereby release Functional Therapeutics from any liability which may result from this disclosure of confidential medical information or which may arise of the result of the use of the information contained in the information released. Unless withdrawn, this consent will expire one year from the date signed.

This information may include Medical/Surgical, Psychiatric, Substance Abuse and HIV/AIDS information.
I authorize that this information may be faxed when applicable.

PATIENT'S SIGNATURE DATE

PATIENT'S REPRESENTATIVE SIGNATURE AND AUTHORITY TO SIGN DATE

WITNESS DATE