Functional Therapeutics
Occupational Therapy

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: _____

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 Unless withdrawn, this consent will expire one year from the date signed.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

Tel: 828.279.5442 • Fax: 828.683.2004 • 5 Covington Street • Asheville • NC• 28806
Web: www.functionaltherapeutics.com • Email: LL@functionaltherapeutics.com