**Release of Authorization to Use and Disclose Health Information**

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the release information no longer will be protected by federal privacy regulations.

By signing this authorization you acknowledge and agree that nearly all treatment performed at Harrington Physical Therapy, PC is done in an open setting where incidental disclosures may occur. Private consultations are available on request. You also agree that Harrington Physical Therapy, PC may use or disclose your personal health information for referral to other health care providers with your permission, any billing or collection activates or proceedings. Additionally there maybe communication via Text, Email or leaving a voice mail regarding scheduling of appointments, your health benefit coverage and related discussion of your care, or phone or mail notifications of any internal office promotions.

**Patient Name: DOB:**

Persons/Organizations **Providing** the Information:  **Harrington Physical Therapy, PC**

Persons/Organizations **Receiving** the Information:

Specific Description of Information (Including Dates):

All health care information in your possession, whether generated by you or by any other source. All Information Regarding Billing of Services by HPT

The patient or the patient’s representative must read and initial the following statements:

1.) I understand that this authorization will  **Expire** on

/ / (DD/MM/YY)

**Initials:**

2.) I understand I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won’t have any effect on any actions they took before the received the revocation.

**Initial:**

*You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.*

*Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.*

*I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this*

*Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.*

Sign: Date:

Description of Representative’s Authority: