

# Campus Physical Therapy Center

At Physicians Medical Center

901 Campus Dr. Suite 213 Daly City, CA 94015

Tel: 650.994.7800 Fax: 650.240.1834

Dr. \_\_\_\_\_ Fax \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ CA \_\_\_\_\_

## Authorization to Use or Disclose Protected Health Information

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Request: \_\_\_\_\_

***As required by the Privacy Regulations, no provider or entity may use or disclose your protected health information except as provided in their Notice of Privacy Practices without your authorization.***

I hereby authorized [name of Physician, Hospital, or healthcare provider] \_\_\_\_\_ or the employees to use or disclose my Patient Health Information to the following person(s), entity (s) or business associates of this office: [name of the requestor] **Campus Physical Therapy Center and Luis E. Araneda, PT DPT** at 901 Campus Drive Suite 213 Daly City, CA 94015 Telephone 650.994.7800 Fax: 650.240.1834.

Patient health Information to authorized to be disclosed:

The Progress Note and Medical Diagnosis, X-rays report, MRI reports, EMG reports that is related to my medical illness, surgery, or work injury sustained on or about: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (date) for the purpose of Physical Therapy Evaluation and Treatments

Effective dates for this authorization: \_\_\_\_\_ through \_\_\_\_\_. This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrolled in a health plan, or eligible benefits whether or not I provide authorization to use or disclosed protected patient health information.

\_\_\_\_\_  
Signature or Patient or Patient's authorized Representative.

\_\_\_\_\_  
Date