

**HIPAA COMPLIANT  
AUTHORIZATION FOR THE RELEASE OF  
PROTECTED HEALTH INFORMATION**

RE: \_\_\_\_\_

This Authorization authorizes the release of Protected Health Information pursuant to 45 CFR sections 160 and 164.

1. The undersigned authorizes **Matt Smith Physical Therapy** to release copies of the following information: any and all medical records and billing statements including, but not limited to, notes, memoranda, correspondence, telephone call records, conclusions, diagnosis referrals, recommendations, physical therapy and rehabilitation records and notes, records or health care providers or any other written documentation relating to my treatment and/or care.
2. The information may be disclosed by employees or business associates of **Matt Smith Physical Therapy**.
3. The information may be disclosed to: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OR ANY OF ITS REPRESENTATIVES OR DULY AUTHORIZED AGENTS**

4. The disclosure may be made for the following purpose: **investigation, negotiation, litigation, conclusion and/or settlement of my bodily injury claim.**
5. This authorization will remain valid until the claim settles, or otherwise concludes, through negotiation and/or litigation however, in no case will this authorization remain valid for more than three (3) years from the date signed.
6. I acknowledge:
  - a. that I have the right to revoke the authorization in writing sent by certified mail to **Matt Smith Physical Therapy** and
  - b. that I understand that once the information is disclosed, it may no longer be protected by federal privacy law. The revocation shall be effective only upon receipt, except:
    - I. to the extent that **Matt Smith Physical Therapy** has acted in reliance on the authorization or
    - II. the authorization was obtained as a condition of obtaining insurance coverage and the insurer wishes to use the protected health information to lawfully contest a claim.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Patient's Name: \_\_\_\_\_

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

Patient's SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

If person signing is other than patient, state authority under which signature is made:  
\_\_\_\_\_

