

Sports Therapy and Rehabilitation

www.starptcenters.com

84 Highland Ave Suite 201
Salem, MA 01970
Phone: (978) 741-0880
Fax: (978) 740-5595

900 Cummings Center, Suite 130-S
Beverly, MA 01915
Phone: (978) 524-7827
Fax: (978) 524-7828

AUTHORIZATION TO USE AND DISCLOSE PATIENT INFORMATION

As a patient of Sports Therapy and Rehabilitation Center, Inc. you have the right to know how we may use and disclose information about you. Information about our disclosures is provided in our Notice of Patient Privacy Practices, and a copy of this notice will be provided to you upon request. You have the right to review our notice before signing this form. You should read our Notice carefully before signing this form. As our Notice of Privacy Practices explains, we need your authorization to use or disclose information about you for any purpose other than treatment, payment or normal healthcare operations.

1. I authorize the use and disclosure of my protected health information for the following purpose(s):
Receiving, Billing, Authorization and/or Extension for Outpatient Physical Therapy Services.
2. By initialing and signing below, I authorize the use and disclosure of the following types of protected health information that may pertain to any health care that I received to date:
(Please initial the category of information you wish to authorize use and disclosure)

My entire physical therapy medical record _____

The following specific information _____

3. I authorize my protected health information to be disclosed to:
My Primary Care Physician, Referring Physician, Health Care Insurance Company, Utilization Review Company and/or My Representing Attorney
4. **I HAVE BEEN TOLD THAT INFORMATION OTHERWISE PROTECTED BY LAW AND DISCLOSED UNDER THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE, AND MAY NO LONGER BE PROTECTED BY LAW, INCLUDING BUT NOT LIMITED TO PRIVACY REGULATIONS ISSUED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.**
5. I agree that this authorization for use and disclosure of my identifiable health information will be effective from the date I sign this document until this authorization expires or until I revoke this authorization. I understand that I may revoke this Authorization at any time by giving Sports Therapy and Rehabilitation Center, Inc. notice in writing at 84 Highland Avenue, Salem MA 01970. I also understand that treatment, payment, enrollment in a health plan, or eligibility for certain health benefits cannot be conditioned on my providing this authorization.

By signing below I agree that my protected health information may be used or disclosed as described above:

**PRINTED NAME OF
PATIENT:** _____

Signature of Patient or Legally Authorized Representative

DATE

Sports Therapy and Rehabilitation Center, Inc. Authorized Representative: _____