AUTHORIZATION TO RELEASE PATIENT INFORMATION

322-A North Buckmarsh, Berryville, VA 22611
(540) 955-1837 **(540) 955-1838 fax** **info@berryvillept.com**

(1) Patient's Full Name: ____ **Today's Date**: ___/___/_______

Date of Birth: ___/___/_______ **Insurance ID as written on the card**:________________________________

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(2) Berryville Physical Therapy & Wellness (BPTW) will only disclose the protected health information you want disclosed. Check one box to tell BPTW what you want disclosed / released.

☐ Do NOT release any information other than for treatment or payment (skip section's 3, 4, 5)
☐ Limited information (complete all sections)
☐ ALL records regarding my care at BPTW (skip section's 3 and 4)

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(3) Complete *only* if you selected "limited information". Please initial all that apply:

___ Evaluation ___ Attendance ___ Correspondence re: Your Physical Therapy Services
___ Treatments ___ Past Medical History ___ Other ______________________________________

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(4) Complete only if you selected "limited information". "I only authorize the release of information to the individuals / entities identified below by name:

Spouse:___________________________________ Attorney: ___________________________________
Parent: ___________________________________ Employer: ___________________________________
Friend: ___________________________________ School: ___________________________________
Other: ___________________________________ Other: ___________________________________

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(5) Check *only* one box indicating how long BPTW can use this authorization:

☐ Disclose my information indefinitely (as long as BPTW has custody of my files)
☐ Disclose my PHI for the following period beginning ___/___/_______ and ending ___/___/_______

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(6) Please initial all items below indicating you have read and understand the rights or information below;

_______ I understand that this authorization does not expire unless I have indicated an expiration date above
_______ I understand that I can refuse to give authorization without fear of retaliation or treatment limitations
_______ I understand that if I give authorization, I may revoke it at any time by notifying BPTW in writing
_______ I understand that the information used/disclosed as a result of my authorization may be subject to re-disclosure by the recipient and may not be protected by Federal privacy regulations once in the recipient's possession
_______ I understand that if BPTW requests my authorization it is required to tell me the purpose and to whom my PHI (protected health information) is being released to
_______ I understand that I will receive a copy of this authorization after I sign it and before I sign, if I request it
_______ BPTW will not be compensated for using or disclosing my PHI unless related to treatment or payment procedures unless specific permission is obtained by the patient after full disclose of purpose & intent

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(7) Please send / release my information to:

Name:_______________________________________ Phone:__________________ Fax: __________________
Address: ____

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(8) Fees for records:

Records Request: $10 Search & Handling + PRINTED= .5-pp 1-50pp, then .25pp ELECTRONIC .37pp 1-50, then .18pp + $5-10 S&H
***We reserve the right to waive fees the 1st patient request.** (We may estimate the page count by using 2 pages per SOAP, 3 Pages per Eval, PT, etc)

____ OR ____

Signature of Patient — Signature of Parent or Authorized Representative **(Indicate the Relationship)**

You May Refuse to Sign this Authorization

1.28.2020