Authorization to Use or Disclose Protected Health Information

Patient name: ____ Date of birth: _____________________________

My Authorization
Rehabilitation Physicians of Pittsburgh may use or disclose the following health information (check all that apply):
☐ All health information in my medical record
☐ Health care information in my medical record relating to the following treatment or condition(s):
____
☐ Health care information in my medical record for the date(s): ____
☐ Other (e.g., X-rays, bills) – specify date(s): ____

Uses and Disclosures Requiring Special Authorization:
HIV, mental health, and drug/alcohol information contained in the records will be released through this authorization unless otherwise indicated. Do not release: ☐ HIV/AIDS ☐ Drug/Alcohol ☐ Mental Health (Psychiatric)

You may disclose this health care information to (Name/organization):____

____

Reason(s) for this authorization to use or disclose my health care information (check all that apply):
☐ Continuing Treatment
☐ Insurance and/or Legal
☐ Other (specify) ____

This authorization ends:
☐ When my treatment ends
☐ On (date):
☐ 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment)

My Rights
I understand that I do not have to sign this authorization in order to get healthcare benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an authorization form to:

- Receive research related-treatment in connection with research studies or
- Receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by Rehabilitation Physicians of Pittsburgh in reliance on this authorization before it receives my written revocation.

I may not be able to revoke this authorization if its purpose was to obtain insurance.

Two ways to revoke this authorization are: 1) Fill out a revocation form-a form is available from Rehabilitation Physicians of Pittsburgh or 2) Write a letter to Rehabilitation Physicians of Pittsburgh

Protection after Disclosure
I understand that once my health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer protect it.

____ ____
Patient signature (or legally authorized individual) Date Time

____ ____
Printed name **Relationship** (parent, legal guardian, personal representative)