HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Ace, 45 C.F.R. Parts 160 & 164)

1) *Authorization* – I, ____________________, hereby authorize New York Sports & Physical Therapy Institute, its affiliate, or agents to use and disclose the protected health information described below to any third party payer and/or the individuals I designate below:

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2) *Effective Period* – This authorization for release of information covers (select one of the following):
   - o A) The period of healthcare from _____________to ________________.
   - o B) All past, present, and future periods of healthcare at this facility.

3) *Extent of Authorization* – I authorize the release of my complete health record (select one of the following):
   - o A) including all records which may include records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse
   - o B) with the exception of the following selected information:
     - o Mental Health Records
     - o Communicable Diseases (including HIV and AIDS)
     - o Alcohol/drug abuse treatment
     - o Other (please specify): ______________________

4) *Use of Information* – This medical information may be used by New York Sports & Physical Therapy Institute, its affiliates, or agents for medical treatment or consultation, billing or claims payment, or other purposes related to my care and reimbursement for my care.

5) I understand the following in regards to this authorization:
   - ▪ The information used or disclosed by New York Sports & Physical Therapy Institute, its affiliate, or agents pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
   - ▪ I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective the extent that any person or entity has already acted in reliance on authorization or authorization was obtained as condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

____ ___________________
Signature of Patient or Personal Representative Date

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Printed Name of Patient or Personal Representative