Physical Rehabilitation Group, LLC

Request/Authorization for Patient Health Information Release

Patient Name: _____ **Date of Birth:** _____

Social Security #: _____ **Patient Account #:** _____

Date of access / release request: _____

At the request of the individual, I _____ (Patient Name) do hereby authorize _____ (Facility Name)

Dates of: _____

____ Progress Notes	____ Discharge Summary	____ EMG/NCS
____ Operative Notes	____ History & Physical	____ Laboratory Reports
____ Physical Therapy Notes	____ Radiology Reports/Films	____ Emergency Reports

____ *** All information retaining to the dates of treatment listed above

Information Release To:

Facility, Company, Person, Agency: _____

Address: _____

Phone (____) ____ - _____ Fax (____) ____ - _____

I understand that Physical Rehabilitation Group, may charge me all applicable copy fees and/or postage fees for a personal copy or for the permanent transfer of your records.

Purpose of Disclosure:

____ Referral to Specialist	____ Insurance	____ Worker's Comp.
____ Legal / Attorney Request	____ Disability Determination	____ Change of Physician
____ Personal	____ Continuing Care	

____ Other (Specify) _____

I hereby authorize disclosure of the health information for the above patient. I understand that Physical Rehabilitation Group, is given thirty days to process my request for access if my information is maintained on-site, sixty days if the information is maintained off-site, and that Physical Rehabilitation Group, may extend the deadline by an additional thirty days if I am notified in writing of the extension. I understand that this authorization is valid until a written notification is received to cancel. I further understand that my rights are limited to any information in my "designated record set" as defined in Section 164.501 of the Code of Federal Regulations. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would no longer be protected by federal regulations.

By signing below, I acknowledge and agree to the above conditions.

_____ _____

Signature of Patient/Guardian/Representative Date

Corporate Office – P.O. Box 3408, Irmo, SC 29063 (P) 803-732-5887 (F) 803-732-5997