MONTOYA
PHYSICAL THERAPY
AND WELLNESS

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize Montoya Physical Therapy and Wellness to use or disclose my health information during the term of this Authorization to my primary or referring physician.

Recipient: I authorize my health care information to be released to the following physicians:

- ***Primary*** Physician:_____
- Primary Physician Address:_____
- ***Referring*** Physician:_____
- Referring Physician Address:_____

Purpose: I authorize the release of my health information to my doctor for monitoring my progress in physical therapy.

Information to be disclosed: I authorize the release of all of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]

Term: I understand that this Authorization will remain in effect from the date of this Authorization until my discharge from physical therapy.

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at Montoya Physical Therapy and Wellness. If I change my mind, I understand that I can revoke this authorization by providing a written notice to staff at Montoya Physical Therapy and Wellness. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

_____ _____ _____
Signature Date Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

_____ _____ _____
Name Relationship Date

[1] NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.