I CAN PT
DOCTORS OF PHYSICAL THERAPY

Monday-Friday 7am-6pm
Phone: 208-789-0200
Fax: 208-288-2784
ican@ican-pt.com
www.ican-pt.com

Authorization for Release of Protected Health Information

Patient Name: _____ Patient Date of Birth: _____

Mailing Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

I request/authorize that my protected health information (PHI) from I CAN PT Doctors of Physical Therapy to be disclosed to:

Recipient Name: _____ Phone Number: _____

Mailing Address: _____ City/State/Zip: _____

Fax: _____ Relation to Patient: _____

PLEASE NOTE: A FEE MAY BE CHARGED FOR CD OR US MAIL

I authorize the following PHI to be released from my medical record(s):

☐ Patient information for visits of I CAN PT LLC
☐ Billing records: Statements of charges and payments
☐ Specific Lab/x-ray/Report: _____
☐ Other:_____
☐All Records, or related to the period from: _____to: _____**OR** All past, present and future encounters/visit up to expiration date or 180 days, whichever comes first.

If you do not wish to release records containing information regarding the diagnosis or treatment of HIV/AIDS, other sexually transmitted disease, drug and or alcohol abuse, mental illness or psychiatric, please initial here____. **Unless initialed here this information is deemed permissible to release.**

Disclosure Format (Paper is default if not marked) Please Circle an Option: US Mail - Paper Format / Fax / CD

RESTRICTIONS: Only medical records originated through this clinic will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. Please allow us 30 days to process your request.

This authorization is valid for **180 days**, unless revoked or expires on: _____

Notice to Patient

Based on the authorization, your request may be subject to reproduction fees in accordance with federal/state regulations. When information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. You have the right to revoke the authorization in writing except to the extent that the practice has acted in reliance upon this authorization. Your written revocation must be submitted to the Privacy Officer at I CAN PT LLC. Financial remuneration may be received by a third party for marketing purposes. You do not have to sign this authorization and that your refusal to sign will not affect your consent to use or disclosure of your protected health information for purposes of treatment, payment or health care operations. Photocopies, facsimile, or scan of this Authorization shall be considered to be the same as a signed original.

_____ _____
Patient's Signature Date Print Patient's Name

_____ _____
Signature of Parent or Personal Representative Date Print Personal Representative Name*

FOR OFFICE USE ONLY - Type of Identification: ☐ Driver's License ☐ Student ID ☐ Other ID

*If Personal Representative is signing then supporting documentation must accompany this form.