Ability Occupational Therapy Services, LLC

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

If you wish to authorize additional individuals or organizations to receive your protected health information please complete this form. Please remember that as outlined in the **Notice of Privacy Practices**, **Ability Occupational Therapy Services, LLC** is authorized to provide health information to people and entities for the purpose of coordinating care related to Occupational Therapy as well as for other stated reasons.

Patient Name: _______________________________ DOB: ________________

Ability Occupational Therapy Services, LLC is authorized to release patient health information as follows:

Information to be used or disclosed:	Entire record including, without limitation, personal health information and other records pertaining to treatment, payment or services sought or received, including non-medical services and the records listed below
Name of Additional Organization(s), person(s), or class of persons authorized to receive health information:	(see table below)
Authorization Expires On:	If this is not completed, Authorization expires one year from date of signature.

Name of person or organization	Purpose	Contact Information

1. I understand that I have the right to revoke this authorization, except to the extent that it has already been relied upon or records have already been released. I may revoke this authorization by writing to the provider to whom this was provided.
2. I understand that information disclosed under this Authorization may be redisclosed by the recipient. The federal privacy rules may not protect my health information once the recipient rediscloses my health information.
3. I understand that I may decline to sign this authorization. I understand that covered entities may not refuse to treat me or otherwise condition benefits on signing this authorization, except that a provider may refuse to provide me with research-related treatment if I do not authorize use or disclosure of my health information for research purposes. Also, if the purpose of my treatment is solely to disclose health information to a third party, the provider may refuse my treatment if I do not agree to authorize disclosure of my health information to that third party.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND
THAT I UNDERSTAND THIS AUTHORIZATION FORM

Signature (Authorized Representative)	Date
Description of Authorized Representative's authority to act for the patient:	