Endurance
PHYSICAL THERAPY

Authorization to Use and Disclose Patient Information

As a patient of Endurance Physical Therapy, you have the right to know who we may use and disclose information about you. Information about our disclosures is provided in our Notice of Patient Privacy Practices, which can be viewed on our website, or a copy can be provided to you upon request. You have the right to review our notice before signing this form.

As our Notice of Privacy Practices explains, we need your authorization to use or disclose information about you for any purpose other than treatment, payment, or normal healthcare operations.

You should be aware that information otherwise protected by law and disclosed under this authorization may be subject to re-disclosure, and may no longer be protected by law, including but not limited to privacy regulations issued by the US Dept of Health and Human Services.

I agree that this authorization for use and disclosure of identifiable health information will be effective from the date signed until one year from my last appointment in the clinic, or until _____, or until I revoke this authorization. I understand that I may revoke this authorization at any time by giving notice in writing.

I hereby authorize my protected health information to be disclosed to:

_____

_____

Signature of Patient or Legal Representative Date