Sutherland Physical Therapy
5108 Northwind Blvd.
Valdosta, GA 31605
Phone: 229.244.1201
Fax: 229.244.1207

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Date _____ DOB _____

Full Name _____

Address _____

(City, State, Zip) _____

Cell Number _____ Work Number _____

I authorize the release of my Protected Health Information voluntarily to the facility listed below:

Sutherland Physical Therapy
5108 Northwind Blvd
Valdosta, GA 31605
Phone 229-244-1201 Fax 229-244-1207

Purpose for Release of Information:

___ Moving ___ Personal ___ Transfer of care
___ Attorney ___Insurance ___ Other: _____

Specific Information Requested:

_____ Progress Note Date(s): _____
_____ Radiology reports Date(s): _____
_____ Surgical Notes Date(s): _____
_____ Billing Date(s): _____
_____ Other: Date(s): _____

I understand I do not have to sign this authorization in order to receive health care benefits and that I may revoke this authorization in writing. I also understand that such revocation would not affect any actions already taken by Sutherland Physical Therapy based upon this authorization and that I may not be able to revoke this authorization if its purpose was to obtain insurance. Furthermore I understand that once health care information is disclosed, the person or organization that receives it may re-disclose it and privacy laws may no longer protect it.

This authorization is valid for ONE YEAR from the date of signature.

_____ _____
Patient/Guardian/Legal Representative Date