Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Leading Edge Physical Therapy to use and/or disclose certain protected health information (PHI) about me to ___________________________.

This authorization permits Leading Edge Physical Therapy to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

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The information will be used or disclosed for the following purpose: “at the request of the individual.”

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire 1 year from date of signature.

I do not have to sign this authorization in order to receive treatment from Leading Edge Physical Therapy. In fact, I have the right to refuse to sign this authorization. When my 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. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:
Leading Edge Physical Therapy
500 South Florida Ave #620
Lakeland, Fl. 33801
Ph.: 863-688-1800 Fax: 863-688-1824

Signed by: ________________________________ _________________________
Signature of Patient or Legal Guardian Relationship to Patient

_________________________________ ______________ _________________
Print Patient’s Name Date Patients Date of birth

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Print Name of Legal Guardian, if applicable patient/guardian must be provided with a signed copy of this authorization form.