415 Crosslake Drive Ste. B,
Evansville, IN. 47715
Phone: 812-476-0409
Fax: 812-476-1016

Authorization for the Disclosure of Health Information

Patient Name: ____ DOB: __________________

Address: ____

City: ____ State: _________ Zip Code: ________________

Day Number: ____________________________________ Evening Number: ______________________________

I authorize ProRehab to disclose a copy of my specific protected health information described below, to be disclosed to:

Name/Facility: ____

Address: ____ City: _________________________

State: __________ Zip Code: ________________ E-mail: ____

Telephone number: _______________________________ Fax number: ___________________________________

Purpose for disclosure (circle): personal record Legal Insurance Continuation of care

Other (please describe) ____

Specific information to be disclosed:

____

____

____

____

Dates of treatment: from ____________ to ______________ OR ______ All past, present and future information

Disclosure method requested:

- _____ Copy of protected health information mailed to: address above
- _____ Copy of record to be picked up; date for pick up ____
- _____ Fax a copy of record (Healthcare provider only): ____
- _____ E-mail (unsecured format, i.e. gmail, hotmail) ____
- _____ CD

You may request that an electronic record be sent, however, be advised that unencrypted CD or email is not secure and can be opened and read by parties other than you.

By signing this authorization form, I understand that:

- I understand there may be a fee associated with this request.

- I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.
- I understand that I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to ProRehab attention: Health Information Management Department, 415 Crosslake Drive, Suite B Evansville, IN. 47715. However, revocation will not have an effect on any actions ProRehab took before it received the revocation.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by federal or state laws regarding the privacy of my protected health information.
- I understand that treatment, payment, enrollment or eligibility may not be conditioned on whether I sign this authorization.
- This authorization will remain in effect until____ (date/event/condition specified by the patient). If I fail to specify an expiration date or event, this authorization will expire sixty (60) days from the date on which it was signed.
- I understand I have a right to a copy of this authorization, a copy of this authorization is valid as an original.

____ __________________________

Patient or Authorized representative Signature Date

____ ____

Print Name Relationship to Patient