HIPAA RELEASE OF INFORMATION AUTHORIZATION FORM

Carefirst Therapies

Section 1

I hereby authorize Carefirst Therapies and its affiliates, employees and agents to release to:

- O Spouse ______________________
- O Family ______________________
- O Other ______________________
- O Information not to be released to anyone.

my or my legal dependents person health information maintained by Carefirst Therapies (e.g., information relating to the diagnosis, treatment, claims payment and health care services provided or to be provided and which identifies me or my legal dependents name, address, social security numbers, member ID number) except the following information:

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for legal proceedings, law enforcement, abuse, neglect or public health safety or for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person or organization and may no longer be protected by applicable federal and state privacy laws. This authorization is valid from the date of my or my representative's signature below. I understand I have the right to revoke this authorization by providing written notice. However, this authorization may not be revoked if Carefirst Therapies, its employees or agents have taken action on the authorization prior to receiving my written notice. I also understand I have a right to have a copy of this authorization.

Carefirst Rehab Physical Therapy

Authorization for Release of Information

Patient name____ Date of Birth_______________

Patient Phone Number____

Address____City_______________Zip_____________

I authorize Carefirst Therapies to disclose my medical records to:

Name____

Address____City_______________State___________

Phone Number____

I authorize Carefirst Therapies to obtain my medical records from:

Name____

Address____City_______________State___________

Phone Number____

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released prior to the written revocation. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to consent under my policy. Unless otherwise revoked, this authorization will expire on the following date:_________________. If I fail to provide an expiration date, this authorization will expire in 60 days from date of signature.

I understand that authorizing the disclosure of this health information is voluntary. I understand I can refuse to sign this authorization. I understand any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules. I understand that if I have been treated for drug or alcohol abuse my records regarding this treatment are protected under the federal regulations governing Confidentiality of Alcohol Drug Abuse Patient Records, 42 CFR Part 2 and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Signature of Patient ____

Date ____

Witness ____