506 Cromwell Ave
Suite 103
Rocky Hill, CT 06067
Phone: (860) 721-9801

Suburban Physical Therapy & Sports Medicine Center, LLC

154 West St
Building 3, Suite C
Cromwell, CT 06416
Phone: (860) 613-0240

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

(Please Print Clearly!)

Name: _____ Date of Birth: _____

Last 4 digits of Social Security #: XXX-XX-_____ Ph #: _____

Address_____ City: _____ State: _____ Zip Code: _____

I hereby authorize Suburban Physical Therapy & Sports Medicine Center, LLC to take the following action:

ACTION REQUESTED (please check one**):**

☐ Provide a copy of **My Health Information** to me:

☐ Release **My Health Information** to (see below)

☐ Obtain copies of **My Health Information** from: _____

_____

For this Authorization, "My Health Information" means (check one or more):

☐ HCFAs (claim forms) ☐ Billing Statements ☐ MD prescription ☐ All Medical Records

☐ Partial Records: Dates from _____ to _____

Reason for disclosure of health information: (please select one)

☐ Personal Use ☐ Dissatisfied ☐ 2nd Opinion ☐ Employment Purposes

☐ Moving Address, City, State and Zip: _____

Ph#: _____

☐ Legal Issues: Date of Accident _____ Attorney Name: _____

Attorney Address, City, State and Zip: _____

Attorney Ph#: _____

☐ Changing Providers: New provider name: _____ Ph#: _____

Address, City, State and Zip: _____

☐ Other Please explain: _____

_____

_____

Expiration of this authorization is 1 year from the date of signature

* I understand that I may revoke this authorization at any time by providing a written notice to Suburban Physical Therapy & Sports Medicine Center, LLC.
* I understand that I may not be able to revoke this authorization if Suburban Physical Therapy & Sports Medicine Center, LLC has already taken action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage.
* I acknowledge that I am signing the authorization freely and no one has coerced or pressured me into signing this authorization.
* I understand that the protected health information disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected by the Federal Privacy Regulations.
* I also understand that if the personal health information that is disclosed under this authorization is confidential HIV/AIDS related information or alcohol or drug abuse related information, Suburban Physical Therapy & Sports Medicine Center, LLC, may not re-disclose that information under the Connecticut State Law.
* I acknowledge that I have carefully review this authorization and understand it's provisions. A copy of the executed agreement will be given to me.

_____	_____	_____
Signature of patient (or patient's legal guardian or representative)	Relationship to patient	Date