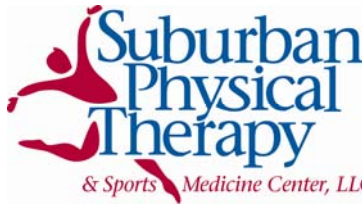


506 Cromwell Ave  
Suite 103  
Rocky Hill, CT 06067  
Phone: (860) 721-9801



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