

HIPAA AUTHORIZATION FORM B

AUTHORIZATION FOR RELEASE OF INFORMATION FOR PURPOSES
REQUESTED BY A PHYSICIAN'S OFFICE FROM ANOTHER COVERED ENTITY
(This brings in your records from other healthcare providers)

I, _____, hereby authorize (insert name of
practice/person) _____
to release the following information, (check those that apply)

- | | |
|---|---|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Activity/Occupational Assessment |
| <input type="checkbox"/> Psychiatric Assessment | <input type="checkbox"/> Clinical & Laboratory Results |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Pregnancy Status |
| <input type="checkbox"/> Treatment Plan/Report | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Vocational Assessment | <input type="checkbox"/> Physician Progress Notes |
| <input type="checkbox"/> Transfer Forms | <input type="checkbox"/> X-ray Reports |

and/or:

to: **Neurological Rehabilitation Resources, P.C. (Dr. Jonathan Woodcock)**
Attn: Sara Burns, 8515 Pearl Street, #203, Thornton, CO 80229 (P) 303-288-7882, (F) 303-288-7874

This PHI is being used or disclosed for carrying out treatment, payment, legal issues, use of an interpreter and/or:

This authorization shall be in force and effect until (specify date) _____ or (specify an event that relates to the patient or the purpose of the use or disclosure) _____
At which time this authorization is to be used and the disclosures expiration.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such a revocation is not effective to the extent that (insert name of practice/person)

has relied on the use or disclosure of the protected health information.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to:

- Inspect or copy the PHI to be used or disclosed as permitted under federal or state law
- Right to refuse to sign this authorization

- Patient's social security # _____
- Patient's Date of Birth: _____

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representatives Authority