SPORTSCARE PHYSICAL THERAPY

Request to Inspect or Copy Protected Health Information

PATIENT INFORMATION

Last _____ First _____ MI _____

Street _____ City/State _____ Zip _____

Date of Birth: _____ Telephone Number: _____

SIGNATURE: _____ Date of Request: _____

RELATIONSHIP (Choose one): ♦ Patient ☐ ♦ Legal Representative ☐ ♦ Other: ☐ _____

Reason for the Request: _____

Disclosures for the Following Dates of Service: _____

Please describe in detail, the information that you would like to examine or copy, as well as reason for request:_____
_____
_____

Specific description of information to be accessed and/or disclosed: Please check all that apply.

♦ My medical records:

♦ Complete medical record (except for mental health and/or developmental disability, substance abuse, and/or HIV/AIDS-related information; must be checked separately)

♦ Only the following portions of my medical record

♦ Therapy notes: Physical, Occupational, and/or Speech

♦ Mental health and developmental disability records

♦ Social Work Notes

♦ Substance abuse records

♦ Nursing Notes

♦ HIV/AIDS-related information records

♦ Physician Documentation

♦ Other: _____

♦ My billing records

Request Access and/or Disclosure for the following dates of service:_____

I have read and understand the following statements:

I understand this Authorization will expire 60 days after I sign this form. Note: If authorization is for disclosure of mental health records, it must have a calendar date expiration or the information may only be disclosed on the current day. Note: If this authorization is for research, an expiration date is not required.

I understand that SportsCare may be allowed by law to refuse to allow access to or disclosure of all or part of my protected health information. If access or disclosure is denied or refused SportsCare will not release the information as requested in this Authorization, and I will be notified of the denial/refusal in writing.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that SportsCare will not condition treatment, payment, enrollment in any health plans or my eligibility for benefits if I decide not to sign this Form.

I understand that I may revoke this Authorization at any time by notifying the SportsCare Compliance Officer in writing, but if I do, it will not have any effect on any actions SportsCare took before it received the revocation.

I understand that there is potential for information disclosed based on this authorization to be subject to re- disclosure by the recipient and no longer be protected by the Privacy Rule.

I understand requests may be subject to a copying fee. If sent to a care provider for continued treatment, there will be no charge.

Signature of patient confirming pick up at facility: (patient must sign here upon pick up at facility)

Address Information if requested information is to be mailed:

Please direct all questions to:

Lisa Fessler

Director, HIPAA Compliance

SportsCare

11 Eagle Rock Avenue

East Hanover, NJ 07936

973-887-9000 X373

LFessler@Sportscare1.com