AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

To:_____

_____

I, _____, _____
(NAME) (SS# or DOB)

request and authorize the above named doctor, health care provider, or its director, designee or records department, to release information contained in my records to O.T. Plus, Inc., or its representative. Permission is also granted for O.T. Plus, Inc. to release information to this provider.

I understand that the information to be released may include information regarding drug and alcohol abuse, communicable/infectious diseases, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), psychological or psychiatric conditions, if any. I understand that if the receiver is not a health plan or health care provider, the released information may no longer by protected by Federal Privacy regulations and may be redisclosed.

Type of information to be disclosed:

( ) Access to complete record
( ) Physician, medical or therapy reports
( ) Records of participation in the program
( ) Other: _____

From: _____ to present.

Purpose of disclosure:

( ) Subsequent treatment
( ) Insurance or Workman's Comp
( ) Other: _____
( ) At the request of patient / patient representative
( ) Litigation

This consent expires on the following condition(s) unless expressly revoked by me:

( ) Upon satisfaction of the need for disclosure
( ) One year from date noted below
( ) Other date: _____

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. To revoke this authorization, I must submit a letter to O.T. Plus, Inc. A facsimile of this authorization with my signature may be used with the same effectiveness as the original.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. All fees and charges will comply with all laws and regulations applicable to release of information.

Signed _____ Date _____
(Client or authorized representative)

Relationship (if signed by representative) _____

Witness _____

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