Divine Spine Physical Therapy and Yoga
7 Centre Dr suite 9, Monroe, NJ 08831
P: 908.444.6055 • F: 732.328.2723

Patient's Authorization to Release Medical Information

In accordance with Federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996, (HIPAA), in order for your healthcare provider or staff of Divine Spine Physical Therapy to discuss your medical condition or billing information with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. A copy of Divine Spine Physical Therapy's Notice of Privacy Practices (NPP) is available upon request. By signing I agree I have received or been given access to the to the NPP.

In accordance with the above, I,_____

Date of Birth: _____ SSN: _____

hereby authorize Divine Spine Physical Therapy to discuss with and release my medical and/ or billing information, scheduling changes to the following individuals:

_____ Myself only

_____ Family Members (specify name) _____

_____ Other (specify name) _____

Furthermore, I understand that if there is any information in my medical record I do *notwant* discussed with or released to the above, I must designate it here by stating what information is to be excluded:_____

I can be contacted at:

Home Phone: _____ _____Work Phone: __ _____ _____

Voicemail/ Answering Machines:

Mobile Phone: _____ _____ _____ Other: _____ _____ _____

------- YES, you may leave messages regarding scheduling, billing, and physical therapy/health information.

_____NO, I do not want messages left on my voicemail or answering machine.

Patients Name (Please Print):_____

Patient Signature:_____Witness:_____

Date:_____