

## AUTHORIZATION TO USE AND DISCLOSE PATIENT INFORMATION

As a patient of Bellingham Physical Therapy, you have the right to know how we may use and disclose information about you. Information about our disclosures is provided in our Notice of Patient Privacy Practices, and a copy of this notice can be provided to you. You have the right to review our notice before signing this form.

You should read our Notice carefully before signing this form. As our Notice of Privacy Practices explains, we need your authorization to use or disclose information about you for any purpose other than treatment, payment or normal healthcare operations.

1. By signing below I authorize the use and disclosure of my protected health information for the following:

- a. allow students of physical therapy, physical therapy assist and/or LMP students to learn and treat my condition when done under the supervision of the attending physical therapist/physical therapy assistant. My entire medical chart (PHI) will be available to be used or disclosed to these students.

**AND/OR**

- b. job shadow, volunteer and/or intern students to observe my physical therapy treatments when accompanied by the attending physical therapist, physical therapy assistant, massage therapist, athletic trainer and/or physical therapy aide. Only verbal information given at time of treatment will be available.

2. I HAVE BEEN TOLD THAT INFORMATION OTHERWISE PROTECTED BY LAW AND DISCLOSED UNDER THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE, AND MAY NO LONGER BE PROTECTED BY LAW, INCLUDING BUT NOT LIMITED TO PRIVACY REGULATIONS ISSUED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

3. I agree that this authorization for use and disclosure of my identifiable health information will be effective from the date I sign this document until I revoke this authorization. I understand that I may revoke this Authorization at any time by giving Bellingham Physical Therapy notice in writing at 306 36<sup>th</sup> St., Bellingham, WA 98226. I also understand that treatment, payment, enrollment in a health plan, or eligibility for certain health benefits cannot be conditioned on my providing this authorization. Revocation of my authorization for use and disclose of information related to drug and alcohol abuse treatment may be provided orally.

By signing below I agree that my protected health information may be used or disclosed as described above.

Printed Name of Patient \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legally Authorized Representative

\_\_\_\_\_  
Date

Authority of Legally Authorized Representative \_\_\_\_\_