

ANNAPOLIS FAMILY PHYSICAL THERAPY

AREA: FEDERAL HEALTH INSURANCE PORTANILITY AND
 ACCOUNTABILITY ACT (HIPAA)
 POLICY: DISCLOSURES TO INDIVIDUALS INVOLVED IN
 PATIENT’S HEALTH CARE
 EFFECTIVE DATE: APRIL 14, 2003 POLICY # 1.32i

BILLING DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT’S CARE

There may be times when it is necessary for the individual directly involved in your care to call the facility or the Privacy Officer to inquire about your personal health information or billing information. Please take a few moments to complete this form.

I authorize AFPT to disclose my health information that is directly related to my current treatment at AFPT to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

Such persons involved in your care may include spouses, children, blood relatives, roommates, boyfriends or girlfriends, domestic partners, neighbors and colleagues.

NAME	RELATIONSHIP

I do not wish to have my health information disclosed to individuals involved in my care as follows:

NAME	RELATIONSHIP

Signature or Patient (or Personal Representative) _____ Date _____

If you are the representative of a patient, check the scope of your authority to act on the patient’s behalf:

Power of Attorney _____ Guardian _____ Surrogate _____
 Executor or Legal rep. _____ Parent _____ Other _____

Provide documentation or explanation of your authority to act for the patient: _____
