Island Therapy Solutions
AUTHORIZATION FOR ACCESS, USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. Failure to provide all information requested may invalidate this authorization.

Patient Name: Date of Birth:

Address: Telephone #:

Date(s) or Treatment: (Note: authorization is not valid prior to care being rendered.)
From date:_____ To date: _____

The specific information to be disclosed from my medical/treatment records includes:

Purpose of Disclosure:_____

Individual(s) or organization(s) authorized to disclose the information:

Name: _____ Telephone: _____ Fax: _____

Address: _____

Individual(s) or organization(s) authorized to receive the information:

Name: _____ Telephone #:_____ Fax: _____

Address:_____

PATIENT RIGHTS:
I understand that signing this authorization is voluntary; Island Therapy Solutions cannot deny me treatment for not agreeing to sign this authorization. I understand that I may see a copy of the information described on this form and that there may be a fee associated for copying. I understand that once the above information is disclosed it may not be under the control of Island Therapy Solutions and may not be protected by federal privacy regulations, therefore there is a potential of unauthorized re-disclosure by the recipient. I understand that this authorization may be revoked by me at any time. I understand that if I do revoke the authorization, I must do so in writing and present my written revocation to be filed in my medical record, which will not apply to information that has already been disclosed in response to this authorization. If I have questions about the disclosure of my health information, I may contact the Privacy Officer of Island Therapy Solutions. I hereby certify that I have read this authorization and agree to it terms.

I understand that my medical records may contain sensitive information relating to AIDS, HIV, psychiatric care, and or treatment for drug and/or alcohol. I give consent for use and disclosure of this type of information. (Please list exclusion, if any)

Client signature if age 14 or older Date

Signature: (Parent/Legal Guardian/Child) Relationship to Patient Date

Island Therapy Solutions Representative Date

EXPIRATION: This authorization is valid for one year from the date of signature, unless the authorization is revoked by written notice.