Action Potential
One on One Physical Therapy

Patient Authorization for Practice to Obtain or Release Protected Health Information

This Authorization for the use and/or disclosure of the specific personally identifiable health information set forth in this Authorization is made pursuant to the requirements of 45 CFR §164.508, which sets out the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 and authorizes Action Potential, LLC (the "Practice") to obtain, use and disclose the personally identifiable health information specifically referenced in this Authorization.

Please read the following information carefully:

I, the undersigned, authorize the use and/or disclosure of personally identifiable health information about me as described below:

1. I authorize the following person(s) or class of persons to use and/or disclose the information:

   ____

2. I authorize the following person(s) or class of persons to receive the information:

   ____

3. The following is a description of the information that I authorize to be used and/or disclosed:

   ____

4. The information will be used and/or disclosed only for the following purposes:

   ____

   ____

5. I understand and acknowledge that if the person or entity that receives the information is not a health care provider, health plan, or other entity covered by the federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

6. **(If applicable)** I understand that the Practice will receive compensation for its use and/or disclosure of the information.

7. I understand and acknowledge 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. I understand that I may inspect or copy any information used and/or disclosed under this Authorization.

8. I understand and acknowledge that I may revoke this Authorization at any time by sending a written revocation to the Practice at the following address: Attn: Compliance Officer, Action Potential, 1786 Wilmington Pike, Suite 100A, Glen Mills, PA, 19342. However, I also understand and acknowledge that if I revoke this Authorization, my revocation will not be effective to the extent that the Practice has already acted in reliance on this Authorization.

9. This Authorization expires ____

   ____________ (insert applicable date or event).

I understand all of the provisions in this Authorization, and I wish to execute this Authorization thereby authorizing the use and/or disclosure of the information described above for the purposes described above.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED THIS AUTHORIZATION AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR THE PURPOSES SET FORTH WITHIN THIS AUTHORIZATION

______________________________________ ______________________
Signature of Patient or Representative Date

____
Patient's Printed Name

______________________________________ ______________________
Patient's Date of Birth Patient's Social Security Number

______________________________________ ______________________
Printed Name of Personal Representative (if applicable) Relationship to Patient

A copy of the completed and signed Authorization form has been provided to the patient or representative:

________Yes ________No

______________________________________ ______________________
Signature of Authorized Practice Representative Date

____
Printed Name of Authorized Practice Representative

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INSTRUCTIONS FOR COMPLETING THE
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION FORM

Please complete the Authorization for Disclosure of Health Information Form in its entirety. Incomplete forms will be returned to the sender for completion.

The patient or legally authorized representative (see #7 below) must sign and date the form.

Please mail or return in person to ACTION POTENTIAL to the attention of the "A&D of Health Information". Emailed electronic copies will also be accepted.

Records will be sent via electronic document portal, or mailed directly to the party listed as the recipient on the authorization form, or recipient may pick up in person with photo identification. We do not fax records to recipients unless needed for emergent patient care by another healthcare provider.

If the records are needed for continuing care purposes and are mailed directly to a physician or other healthcare facility, the records will be provided free of charge.

Records for all other purposes are subject to copying charges in accordance with PA State Law. An invoice will be mailed to you and payment will be expected prior to the records being copied and mailed.

The following is a list of persons authorized to sign the disclosure of health information form:

• If the patient is 18 years of age or older and is competent, then the patient must sign. No one else is authorized to sign.
• If the patient is 14 years of age or older and was treated for a psychiatric admission, then the patient must sign.
• If the patient is a minor (under 18 years of age) or under 14 years of age for psychiatric admission, then the parent or legal guardian must sign.
• If the patient is over 18 years of age and is incompetent, then the legal representative must sign and provide proof of legal representation. (e.g. a photocopy of power of attorney documents or other legal documents).
• If the patient is deceased, the surviving spouse or other legal representative must sign and provide proof of legal representation (e.g. a photocopy of executor documentation, power of attorney, etc.).

Please contact ACTION POTENTIAL if you have additional questions or need further assistance.

FEES FOR THE RELEASE OF MEDICAL RECORDS

Action Potential will charge for copying records in accordance with Pennsylvania Department of Health Notice regulated by Act 26 (43 Pa.B. 7185) and the Health Insurance Portability and Accountability Act (45 CFR Parts 160-164). Copying fees are updated January 1st of each year.

**Request a copy of the current fees or visit the PA DOH website: https://www.health.pa.gov/topics/Administrative/Pages/Medical-Record-Fees.aspx

The fees listed previously shall apply for paper copies or reproductions on electronic media whether the records are stored on paper or in electronic format.

In addition to the amounts listed previously, charges may also be assessed for the actual cost of postage, shipping and delivery of the requested records.

**Note*: Federal regulations enacted under the Health Insurance Portability and Accountability Act at 45 CFR Parts 160—164 state that covered entities may charge a reasonable cost based fee that includes only the cost of copying, postage and summarizing the information (if the individual has agreed to receive a summary) when providing individuals access to their medical records. The Department of Health and Human Services has stated that the fees may not include costs associated with searching for and retrieving the requested information. For further clarification on this issue, inquiries should be directed to the Office of Civil Rights, United States Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, DC 20201, (866) 627-7748, http://www.hhs.gov/ocr/hipaa.

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