RECOVIA
RESOLVE · RECLAIM · RECOVER

Authorization to Release Protected Health Information

Patient Name: _____ DOB: _____

I HEREBY AUTHORIZE RECOVIA, LLC AND RECOVIA PHYSICAL THERAPY, LLC TO RELEASE INFORMATION FROM MY MEDICAL RECORD TO my referring provider/source, providers involved in my care outside of Recovia, family, friends and other 3rd parties:

NAME/MEDICAL GROUP	PHONE/FAX NUMBER	RELATION/PROVIDER
_____	_____	_____
_____	_____	_____
_____	_____	_____

THE PURPOSE OF THIS DISCLOSURE IS FOR:

☐ Medical Care ☐ Attorney Review ☐ Personal Use ☐ Research ☐ Payment
☐ Other: _____

INFORMATION TO BE RELEASED

☐ All Medical Records/Information ☐ Billing Records/Information ☐ Correspondence
☐ Treatment plan ☐ Medications ☐ Progress notes ☐ Nursing notes ☐ Orders
☐ Consult records ☐ Therapy records ☐ Records or results of UDS testing
☐ Information related to: _____
☐ Other: _____
FOR: ☐ Dates of Treatment: _____ to _____ OR ☐ All Dates of Service

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Substance Use Disorder (Alcohol/ Drug Abuse) Treatment/Referral
☐ Mental Health (Other than Psychotherapy Notes)
☐ HIV/AIDS-related Treatment
☐ Communicable Diseases
☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

I understand that my health information may be protected by federal privacy regulations. I understand that the information used or disclosed, except for my Substance Use Disorder Information under 42 CFR Part 2 (if applicable to my records and information), may be subject to re-disclosure by the person or class of persons or facilities receiving it and would then no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time except to the extent that Recovia has already taken action in reliance upon it. I understand that in order to revoke this authorization, I must do so in writing and present my written notice to Recovia, Attn: Medical Records, 337 E Coronado Rd, 2nd Floor, Phoenix, AZ 85004. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization expires one year from the date of signature. A photocopy or scanned signature shall have the same force and effect as the original.

_____ _____
Signature of Patient or Patient Representative and Relation Date