COVENANT HAND THERAPY, PC
1101 Ohio Drive, Suite 105, Plano, TX 75093 - phone 972-599-9594 - fax 972-599-9364

Patient Authorization for Release of Information

Authorization is required for the Use or Disclosure of Information
Related to Treatment, Payment, Healthcare Operations unless otherwise permitted by Law or Rules

Patient's Printed Name: ______________________________

Patient's Date of Birth: ____/____/________ **Social Security Number:** _____/_____/_______

I understand that my provider will need to communicate with my physician about my healthcare. I also understand that in order for my insurance company to process and pay on claims for my treatment, they will also need information about my healthcare; and by denying the insurance company such information, I will need to pay in full in cash for my treatment at this facility.

CHT may release my information to:

My Doctor: ______________________ **My Insurance Company:** ______________________

Other: ______________________________

☑ Yes, you may release this information as long as my file is active unless I herein specify a duration or expiration date.

If No, please specify duration or expiration date: ____________

I direct CHT to release my information to Larry Urben, Custom Footworks ______________________
Sign and Date

CHT may obtain my information:

I hereby authorize Covenant Hand Therapy, P.C. to obtain all medical records and/or professional information FROM my physician or other medical professional AS IT RELATES TO MY CURRENT TREATMENT.

I may request restrictions as to how my health information may be used although CHT is not required to agree to those restrictions if in violation of HIPAA compliance.

I may revoke this authorization in writing at any time, although CHT can proceed with uses and disclosures that pertain to treatment, payment, or healthcare issues that take place before the consent was revoked.

I indicate understanding and consent for use of health information related to our service.

______________________ or ______________________

Signature of Patient **Date** **Signature of Parent/Guardian or Authorized Representative** **Date**