Jefferson City
(P) 865.475.3101
(F) 865.475.9213
102 E. Commerce Ct
Jefferson City, TN 37760
Optimus@optimustherapy.com

Dandridge
(P) 865.895.4080
(F) 865.329.7933
118 E. Meeting St Suite A
Dandridge, TN 37725
Dandridge@optimustherapy.com

PATIENT CONSENT AND AUTHORIZATION
FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Tel: _____ Email: _____

I, _____ hereby authorize the release, use, or disclosure of my health information as follows:

This authorization pertains to the following type of medical information about me:

- ❑ Initial Evaluation
- ❑ Progress Reports
- ❑ Discharge Summary
- ❑ All Physical Therapy Documentations

I hereby authorize Optimus Health Center to release the above-described information to:

_____.

I understand per my request that this authorization will permit Optimus Health Center to use or disclose identifiable health information for purposes beyond treatment, healthcare operations, and billing as provided by the Health Information Portability and Accountability Act of 1996 (HIPAA). I understand that I may revoke this authorization at any time by providing written notification to Optimus Health Center. The revocation will be effective on the date that it has been received by the above-named recipient. I understand that the revocation does not apply to action taken in reliance upon this authorization prior to the effective date of revocation. I also understand that I do not have to sign this authorization in order to receive treatment, payment, or to enroll or be eligible for benefits. Unless I request in writing otherwise, I understand that this will expire on _____. If I do not specify expiration date or event, this authorization will expire 90 days from the date on which I signed this authorization. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the named recipient and may no longer be protected by HIPAA privacy rule after the authorized disclosure.

Signature: _____ Date: _____

Name (Print): _____ Relationship to Patient: _____

Received By: _____ Date: _____