Authorization to Disclose Health Information

Patient Name: ____________________________________ Health Record Number:_______________

Date of Birth: ____________________________________

1. **I authorize the use or disclosure of the above named individual's health information as described below**
2. **The following individual or organization is authorized to make the disclosure:**
   ____

   Address: ____
3. **The type and amount of information that will be used or disclosed is as follows: (include dates where appropriate)**
   ______ **problem list** ______**medication list**
   ______ **list of allergies** ______**immunization record**
   ______ **most recent history & physical** ______**most recent discharge summary**
   ______ **laboratory results** **(from date)**___________**(to date)**____________
   ______ **x-ray & imaging reports** **(from date)**___________**(to date)**____________
   ______ **consulting reports** **from (doctor's name)**___________________
   ______ **entire record**
   Other____
   ____
4. **I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.**
5. **This information may be disclosed to and used by the following individual or organization:**
   ____
   Address:____
   for the purpose of ____
6. **I understand that I have no right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to protest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_________________________________. If I fail to specify any expiratory date, event or condition, this authorization will expire in six months.**
7. **I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact (Robin Proctor, RHIT, Director of Health Information Management/Privacy Officer at 912-367-9841 extension 7270)**

____ ___________________________

Signature of Patient or Legal Representative **Date**

______________________________	______________________________
If signed by Legal Representative, Relationship to Patient	**Signature of Witness**

Appling HealthCare System
Rehabilitation Services
Attendance Policy

In an effort to better serve our patients, an attendance policy has been instituted.

Our therapists reserve the right to reschedule appointments if patients are 15 minutes late for his/her scheduled appointment.

Please notify Rehabilitation services at least 24 hours in advance if you must cancel or reschedule your appointment. We realize that emergency situations do occur, however we greatly appreciate advanced notice.

No Call/No Show Policy- Therapist will discharge a patient after 3 consecutive no call/no shows or two weeks of no therapy services, which ever comes first. No shows discourage progress in therapy. Attendance is highly recommended to improve successful therapy outcomes for you the patient.

If you have difficulty keeping your appointments, the therapist will work very hard to accommodate your schedule. Please tell the therapist and/or secretary if the appointment time needs to be changed.

<u>Thank you for choosing Appling Rehabilitation Services to meet your therapy needs</u>

Please sign to acknowledge receipt of this policy

____Date____________________