Send Request to: Active Therapy, Att: Medical Records, 11810 Nicholas ST, 103, Omaha, NE 68154
PH: (402) 932-2888 FX: (402) 932 - 2899 Email: hello@activetherapyclinic.com

AUTHORIZATION FOR USE OR DISCLOSURE OF / ACCESS TO PROTECTED HEALTH INFORMATION

I, _____ , hereby authorize Active Therapy to use and disclose the protected health information as described below for the following patient:

Patient Name		Date of Birth
Patinet Previous / Other Name(s)		
Street Address		Phone
City	State	Zip Code

I authorize the following person (s) or organization to receive the information:

Name			
Street Address			
City		State	Zip Code
Phone	Fax	Email Adress* (Required for an Electronic Release)	

Records to be Released: (Check all that apply)

- ☐ All Medical Records
- ☐ Itemized Billing Statements
- ☐ Discharge Forms
- ☐ HCFA Forms
- ☐ Other: _____

Dates of tretment to be released:	From:	To:

Reason or purpose for the use and/or disclosure of the information:
(e.g., Attorney, Worker's Comp, Insurance, Disability....)

Send Request to: Active Therapy, Att: Medical Records, 11810 Nicholas ST, 103, Omaha, NE 68154
PH: (402) 932-2888 FX: (402) 932 - 2899 Email: hello@activetherapyclinic.com

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions and/or HIV-related conditions.

Re-Disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPPA) and the receipient of my helath information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirments, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Expiration: This authorization will expire one year from the date signed unless the facility receives a Revocation as outlined below.

Revocation: I understand that I may revoke this authorization at any time by notifing the facility in writing by sending a letter to Active Therapy , Att: Medical Records 11810 Nicholas St, 103, Omaha, NE 68154. I understand that if I revokethis authorization, it will not affect any actions that were taken before the revocation letter was received. I understand that the facility cannot rescind disclosures it has already made and may use my health information as necessary to bill and collect for services rendered.

If this authorization is for the marketing by the covered entity, indicate if the covered entity will receive compensation for the use and disclosure of protected health information. ☐ Yes ☐ No

I understand a fee may be charged for copies of my medical records.

Signature of Patient	Date (Required)
Printed Name	

Signature of Personal Representative	Date (Required)
Printed Name of Personal Representative	
*Rationale for Serving as Personal Representative to the Patient (e.g., parent, legal guardian)	

**Please provide supporting legal documentation such as Power of Attorney, or other legal documents establishing the status of the above named as Personal Representative per 45 CFR 164.502(g).*