Kessler
INSTITUTE FOR REHABILITATION
a Select Medical company

PATIENT ACCESS AND AUTHORIZATION FORM

Section A: This section must be completed for all Authorizations		
Patient Last Name	**First Name**	**MI**
Date of Birth	**Social Security Number (*optional):***	
My health information may be released to (name of recipient):		
Address 1:		
Address 2:		
City:	**State:**	**Zip:**

I hereby authorize the use or disclosure of protected health information as described below: (Is this request for Psychotherapy Notes?)

☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.

☐ No, then you may check as many items below as you need.

Description:	**Date(s):**	**Description:**	**Date(s):**	**Description:**	**Date(s):**
☐ All PHI in medical record (*note exceptions in sensitive information section below)* ☐ Admission Form ☐ History & Physical ☐ Physician orders		☐ Medication Sheets ☐ Lab Tests ☐ Nursing Notes ☐ Discharge Sum ☐ Progress Notes		☐ Initial Evaluation ☐ Therapy Treatment Records ☐ Radiology Films/CD ☐ Billing Record ☐ Other:	

The information authorized for release may include records which may indicate the presence of a communicable/venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and Human Immunodeficiency Syndrome also known as Acquired Immune Deficiency Syndrome (AIDS).

If you would like any of the following sensitive information disclosed, check the applicable boxes

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS related Testing and/or Treatment ☐ Sexually Transmitted Disease ☐ Mental Health (Other than Psychotherapy notes)

☐ Genetic Testing – Provide purpose of disclosure and to whom:_____

Please describe below the exact nature and dates of medical records that you would like to release (e.g. laboratory between 1/1/07 and 3/31/07_____

The purpose of requesting release of this health information is:

I understand that:

1. If the person or entity that receives the above information is a not a health care provider or health plan covered by federal privacy regulations, the information may no longer be protected by the federal privacy regulations and may be re-disclosed.
2. I may revoke this authorization in writing at any time, except to the extent that action has been taken by Select Medical Corporation in reliance on this authorization, by sending a written revocation to: Select Medical Corporation, Attn: Privacy Officer, 4716 Old Gettysburg Road, Mechanicsburg, PA 17055. However, I understand that if my participation in a mental health program is a condition of my release, confinement, probation, or parole, then I may not revoke this authorization.
3. I understand that I am not required to sign this authorization form and that Select Medical Corporation will not condition the provision of treatment or payment to me on the signing of this authorization.
4. A copy or fax of this authorization form is as valid as the original.

Kessler
INSTITUTE FOR REHABILITATION
a Select Medical company

PATIENT ACCESS AND AUTHORIZATION FORM

This authorization will expire 12 months from the date of my signature unless you have specified a shorter duration or event. Shorter duration or event expiration event_____. If resident of Indiana or Texas, this authorization will expire 180 days from the date of my signature. **If a resident of NJ, this authorization will expire 4 months from the date of my signature.**
Resident of Alabama: By checking this box, I consent to follow up upon release of my mental health records as authorized. ☐

(Please turn over to Complete)

PATIENT ACCESS AND AUTHORIZATION FORM

Section B: Signatures I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient (or Patient's Representative)	**Date:**
Print Name of Patient (or Patient's Representative)	

If you are the representative of a patient, check the scope of your authority to act on the patient's behalf:

☐ Power of Attorney ☐ Legal Guardian ☐ Surrogate Decision-Maker
☐ Executor or Personal Representative ☐ Parent ☐ Other: _____

Witness Signature (required if mental health/substance abuse records are being disclosed):

Print Name of Witness: _____

If in the state of PA and patient is only able to give verbal authorization, need to have two witnesses:

Second Witness Signature: _____

*Print name of second Witness:*_____

For Select Medical Use Only: Name of facility disclosing records as authorized: ☐ *Chester* ☐ *Saddlebrook* ☐*West* ☐*Center(specify site):*_____

For Select Medical use only: If disclosing mental health/substance abuse information document when the information was sent, by what means, and to whom it was sent: _____

REV: 1/08