AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO THE OREGON PHYSICAL THERAPIST LICENSING BOARD

As the person who is the subject of protected health information under HIPAA, I request and authorize____
(Name of Physician or Provider)

to disclose my health information described below to the Oregon Physical Therapist Licensing Board.

The information will be used on my behalf to facilitate the Board's investigation of the physical therapy treatment I received.

I specifically authorize and request the disclosure of the following health information and medical records:

Medical Diagnosis and history;

Results of clinical tests;

Medication prescription and monitoring;

Symptoms;

Prognosis;

Progress to date;

Billing statements and payment records;

All other documentation in the record regarding my medical care, including referrals and correspondence.

Please send the entire medical (all information) to the **Oregon Physical Therapist Licensing Board**, **800 NE Oregon Street**, **Suite 407**, **Portland, OR 97232-2187**. I understand that this authorization may be revoked at any time by giving written notice to the physician or provider named above, except to the extent that action has been taken in reliance on this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signature.

I understand that the Oregon Physical Therapist Licensing Board is not a health care provider or a health plan covered by federal privacy regulations and that the information described above may be re-disclosed and will no longer be protected by the HIPAA Privacy regulations. I understand that my signature on this authorization has no relationship to my ability to receive treatment, payment, enrollment or eligibility for benefits.

I also understand that the Oregon Physical Therapist Licensing Board will keep my health information confidential under Oregon law, including ORS chapter 676.

____
Date

____
Print Name

____
Signature