

**AUTHORIZATION FOR USE AND DISCLOSURE OF VERBAL PROTECTED HEALTH INFORMATION
PROGRESSIVE PHYSICAL THERAPY**

Progressive Physical Therapy is authorized to use or disclose my/the individual's Protected Health Information ("PHI") as described below.

Name of Patient (First, Middle, Last): _____ DOB: ____/____/____

Name of Patient at time of treatment if different from above: _____

Name of Employer and/or Workers Compensation Carrier, or their representatives, to receive the PHI

Employer: _____

Street Address/City/State/Zip Code: _____

Workers Compensation Carrier: _____

Street Address/City/State/Zip Code: _____

PHI REQUESTED: Verbal protected health information regarding health care services provided to me at Progressive Physical Therapy that pertains to my workers' compensation claim.

PURPOSE OF DISCLOSURE: Assist employer in processing workers' compensation claims in accordance with the South Carolina Workers' Compensation Act, S.C. Code Ann. §§ 42-1-10 *et seq.*

REVOCACTION: I may revoke this authorization in writing except for uses or disclosures of PHI made by Progressive Physical Therapy in good faith relying on this authorization. To revoke this authorization, I must deliver a signed, written statement clearly stating that I revoke this authorization to the Privacy Official at Progressive Physical Therapy at the following address:

Progressive Physical Therapy
Attn: Privacy Official
100 Jimmy Love Lane
Columbia, South Carolina 29212

COPY: I will receive a copy of this signed authorization if Progressive Physical Therapy is requesting the authorization from me.

EXPIRATION: This authorization expires on the later of (a) one year from the date the authorization is signed or (b) the expiration of my employment with the above-named employer. Upon the conclusion of that time period, this authorization is automatically revoked and no further use or disclosure of the patient's PHI is permitted beyond that date.

CONDITIONS: Treatment, payment, enrollment in a health plan or eligibility for benefits may not be conditioned on whether I sign this authorization. I understand that the PHI disclosed under this authorization may be redisclosed. Such redisclosure may not be protected under Federal Privacy Standards.

SIGNATURES:

Patient: _____ Date: _____

If patient is unable to sign, please state reason: _____

If patient is unable to sign, the signature of a personal representative must be provided:

_____ Date: _____

Relationship: _____ Verification Source: _____

Progressive PT Representative: _____ Date: _____