WEST BILLINGS
Physical Therapy & Sports Medicine
3307 GRAND AVENUE, STE 203 • BILLINGS, MT 59102-6551

HIPAA AUTHORIZATION FORM

I, _____ DOB _____
(Patient Name)

hereby authorize the use or disclosure of my protected health information as described below.

1. **Authorized persons to use and disclose protected health information:**
   West Billings Physical Therapy and Sports Medicine and employees are authorized to disclose the following protected health information to:

   a) _____
   b) _____
   c) _____

The health information that may be disclosed is:

All past, present and future periods of health care information may be shared.

I understand that the information used or disclosed under this authorization form may be subject to re-disclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations.

I have the right to refuse to sign this authorization form. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

_____ _____
Signature of patient or responsible party **Date**

*****I hereby acknowledge that I will be provided a copy upon request of West Billings Physical Therapy Notice of Privacy Practices. I understand that if I have any questions regarding the notice or my privacy rights, I can contact West Billings Physical Therapy.**

_____ _____
Signature of patient or responsible party **Date**