SOS PT, Inc.
Spine-Orthopaedic-Sport Physical Therapy
148 Linden St., Suite B-8, Wellesley, MA 02482
Tel. 781-263-9977 Fax. 781-943-4228

AUTHORIZATION TO USE AND DISCLOSE PATIENT INFORMATION

As a patient of SOSPT, Inc. you have the right to know how we may use and disclose information about you. Information about our disclosures is provided in our Notice of Patient Privacy Practices, and a copy of this notice is available upon request. You have the right to review our notice before signing this form. As our notice of privacy practices explains, we need your authorization to use or disclose information about you for any purpose other than treatment, payment or normal healthcare operations.

1. I authorize the use and disclosure of my protected health information:
   - ☐ To notify all of my healthcare providers of my status verbally and/or in writing.
   - ☐ To assist my health insurance company in processing any of my claims.

2. I authorize the use and disclosure of my protected health information that may pertain to any healthcare I have received to date:
   (please initial the category of information you wish to authorize and disclose)
_____ my entire medical record
_____ my entire medical record, except for the following information:
_____
_____

I HAVE BEEN TOLD THAT INFORMATION OTHERWISE PROTECTED BY LAW AND DISCLOSED UNDER THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE, AND MAY NO LONGER BE PROTECTED BY LAW, INCLUDING BUT NOT LIMITED TO PRIVACY REGULATIONS ISSUED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

I agree that this authorization for use and disclosure of my identifiable health information will be effective from the date I sign this document until this authorization expires or until I revoke this authorization. I understand that I may revoke this Authorization at any time by giving SOSPT, Inc. notice in writing at 148 Linden Street, Suite B-8, Wellesley, MA 02482. I also understand that treatment, payment, enrollment in a health plan, or eligibility for certain health benefits cannot be conditioned on my providing this authorization. Revocation of my authorization for use and disclosure of information related to drug and alcohol abuse treatment may be provided orally.

By signing below I agree that my protected health information may be used or disclosed as described above.

_____
Name of Patient (please print)

_____ ____/_____/____
Signature of Patient (or legally authorized representative) Date