Tririga Rehab

800 W LONG LAKE RD, SUITE 103
BLOOMFIELD HILLS, MI 48302
Phone: (248) 480-0900 Fax: (248) 282-8416 Email: tririgarehab@gmail.com

Authorization for Release of Information

Name: _____ **Date of Birth:** _____

Address: _____ **City, State, Zip:** _____

PURPOSE OF THIS REQUEST: (check one) ☐ **Healthcare** ☐ **Insurance Coverage** ☐ **Personal** ☐ **Other**

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate)

☐ **Assessments** ☐ **Progress Notes** ☐ **Laboratory Test Results:** _____

☐ **Diagnostic Impression** ☐ **Discharge Summary** ☐ **Treatment Plans**

☐ **Treatment Summary**

☐ **Other: (**please describe)_____

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- I may cancel this authorization at any time by submitting a ***written*** request to the Tririga Physical Therapy & Rehab, except where a disclosure has already been made in reliance on my prior authorization.
- If the person of facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
- If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- Release of HIV-related information requires additional information.

Patient Signature or Representative: _____ Date: _____