HIPAA Authorization Form

I, _____, give permission to Rehabilitation Professionals, Inc. to use the following protected health information and/or disclose the following protected health information to Rehabilitation Professionals, Inc.

Information to be disclosed:

Medical Records
Treatment Records
Diagnostic Records

This protected health information is being used or discussed for the following purposes:

Treatment
Payment
Day to Day Operations of RPI

This authorization expires six years after form is signed.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or your eligibility for benefits.

Finally, you may revoke this authorization in writing at any time by sending written notification to:

Jonty Felsher
Rehabilitation Professionals, Inc
1034 S. Brentwood Blvd, Suite 300
St. Louis, MO 63117

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed Name Relationship/Authority