FIT Physical Therapy & Dance Medicine
122 Spring St Unit D4
Southington CT 06489
860-690-9796
Stephanie L Foresi MSPT. LISC# 005853

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION PHI

Patient Name: _____

Date of Birth: _____ Age:_____

Phone: _____

1. AUTHORIZED ENTITIES

I hereby authorize **Stephanie Foresi MSPT at FIT Physical Therapy & Dance Medicine PLLC** to exchange, disclose, and receive my protected health information (PHI) with the following healthcare provider(s):

- **Provider/Clinic Name: _____**
- **Specialty/Facility: _____**
- **Phone/Email: _____**

2. SCOPE OF INFORMATION TO BE DISCLOSED

(Circle all that apply)

- **All Medical Records** (Includes initial evaluations, progress notes, daily treatment notes, discharge summaries, and home exercise plans)
- **Specific Records Only: _____**
- **Verbal Communication & Care Coordination Only** (Discussion of clinical findings and plan of care)

3. PURPOSE OF DISCLOSURE

This information is being shared for the purpose of **Continuity of Care, Clinical Collaboration, and Treatment Coordination**.

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4. CONCIERGE & CASH-BASED PRACTICE DISCLOSURE

By signing below, the patient acknowledges that **FIT Physical Therapy & Dance Medicine PLLC** operates as a concierge, out-of-network, cash-based clinic. Because we do not bill insurance or clear claims through electronic clearhouses, the records shared under this authorization are intended strictly for clinical coordination and will not contain insurance codes, authorization data, or insurance-specific billing modifiers.

5. PATIENT RIGHTS & REVOLCATION

- **Right to Revoke:** I understand that I have the right to revoke this authorization in writing at any time by sending a written notice to the privacy officer at **FIT Physical Therapy & Dance Medicine PLLC122 Spring St Unit D4, Southington CT.**
- Revocation will not apply to information that has already been released in reliance on this authorization.
- **Voluntary Signing:** I understand that signing this form is voluntary. My refusal to sign will not condition or restrict my ability to receive treatment at this practice.
- **Redisclosure Risk:** I understand that once my health information is disclosed to the recipient named above, it may no longer be protected by federal or state privacy regulations and could potentially be redisclosed by the recipient.

6. EXPIRATION

This authorization will automatically expire **one (1) year from the date of signing**, or upon the following specific event or date: _____

Patient / Legal Representative Signature:

_____

Printed Name & Relationship (if Representative):

_____

Date: _____