Ability Health & Rehabilitation, LLC.
4696 W. Overland Rd. #224, Boise Idaho 83705
Phone: 208-333-9578
Fax: 208-33-9582

Participant Consent to Obtain or Release of Information Disclosure Form

Participant Name: _____ DOB:_____

Address: _____ Phone: _____

- ☐ I hereby give _____ my authorization to disclose my protected health and/or personal information. Below describes the information that I am requesting you disclose to _____.
- ☐ I hereby give _____ my authorization to obtain my protected health and/or personal information. Below describes the information that I am requesting you obtain from _____.

Specific description of information to be disclosed:

☐ Assessments ☐ Treatment Plans ☐ H&P
☐ Medication List Other: _____
☐ Exchange of Information regarding treatment
☐ In patient records: Dates: _____
☐ Reason: _____ Expires on: _____

I understand that this authorization provides that:

- I have the right to access my protected health information to be used or disclosed.
- I may revoke this authorization at any time in writing to the address listed above.
- Information used or disclosed pursuant to this authorization may be subject to re-discloser by the recipient and no longer be protected by HIPAA privacy rules.
- This practice will not condition my treatment on my providing authorization for the requested use or disclosure.
- I will receive a copy of this completed and signed authorization form.

Participant/Legal Guardian Signature: _____Date: _____
Relationship to participant:_____
Agency Staff: _____ Date: _____