HIPPA AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize use or disclosure of protected health information for patient as described below:

Records on (Patient Name) ______________________________ **(DOB)** ________________

The following person or class of persons may receive disclosure of protected health information about me:

Name: ______________________________ **Relationship:** ______________________

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Name: ______________________________ **Relationship:** ______________________

Specific description of information to be released: ______ **ALL** *or as listed:*

____

The information to be released will be used for the purpose described: ____ **Personal Health Care** *or as listed:*

____

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would no longer be protected by federal privacy regulations.

I may revoke or withdraw this authorization by notifying ActiveFit Rehab Physical Therapy in writing of my desire to revke it. However, I understand that any action already taken in advance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition treatment of me on whether or not I sign the authorization.

______ ***(Initial)*** This authorization will **NOT** expire Until I Revoke or Change it.

OR

______ ***(Initial)*** This authorization will expire ______ year(s) from date signed.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

______________________________ Date: ________________ Date of Birth: ________________

Signature Of Patient

ActiveFIT Rehab Physical Therapy
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