AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (RELEASE OF INFORMATION)

I, _____ (Date of birth: _____), authorize Refresh Therapy Inc., to disclose and/or obtain Protected Health Information (PHI) about me. I give my permission to mutually exchange information with:
Name: _____

Address: _____

Phone: _____ Fax: _____

For the following purpose: _____

This authorization expires on _____

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is stricter than HIPAA and provides additional privacy protections.

I understand that I may revoke this authorization at any time by notifying Refresh Therapy Inc. in writing of my desire to revoke it. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my PHI. By my signature below, I hereby knowingly and voluntarily authorize Refresh Therapy Inc. to use or disclose my health information in the manner described above.

_____

Client Signature Date

_____

Child's Name (if applicable) Date

_____

Therapist Signature Date