

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Telephone No.: _____

Date of Birth: _____

I, _____, hereby authorize BodyForward and/or its affiliated health care providers to disclose the above-named patient's protected health information, as described below, to _____. The information to be disclosed is (check all that apply):

Progress notes;

Complete treatment record;

Complete record including, but not limited to, insurance and demographic information and records from other providers;

Other: _____

The information may be disclosed in the following manner (check all that apply):

Electronic transmittal;

Paper copy;

Orally;

Facsimile.

The purpose of this disclosure is Client request or Other _____

This authorization shall be valid for one year or until I notify BodyForward and/or its affiliated health care providers that I wish to revoke my authorization. I understand that neither BodyForward and/or its affiliated health care providers shall not be liable for the release of any protected health information prior to the revocation of this authorization.

Signature of Patient or Legal Representative

Date

Print Name of Patient or Legal Representative