AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ____________________________ Telephone No.: ____________________

Date of Birth: ______________________

I, _______________________________, hereby authorize Body Forward and its affiliated network of 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 Body Forward and/or its affiliated health care providers that I wish to revoke my authorization. I understand that neither Body Forward 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

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Print Name of Patient or Legal Representative