

Innovative Spine Rehab / WLRPT

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I _____ hereby authorize the use and disclosure of individually identifiable health information relating to me, which is called "protected health information" under a federal health privacy law, as described below:

Specific Description of the Information to be Used or Disclosed Including the Dates of Service(s):

Persons or Class of Persons Authorized to Make the Use or Disclosure:

Persons or Class of Persons to Whom the Use or Disclosure May Be Made:

**The protected health information will be used and/or disclosed for the following purposes:
(Please list each purpose of the use(s) or disclosure(s) in the space provided.)**

At the request of the individual (check box if applicable).

Other:

I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulation, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I may revoke this authorization at any time by notifying WLRPT in writing. However if I choose to do so, I understand that my revocation will not affect any actions taken by WLRPT before receiving my revocation.

I understand that I may refuse to sign this authorization and that my refuse to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

Signature of individual or individuals representative

Date

Printed name of individuals representative

Basis of representatives authority to act for individual: _____

This authorization expires on: ____/____/____ (one year anniversary)