AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, ___________________________________, authorize the disclosure of my protected health information as described herein. I understand that this is voluntary and made to confirm my direction. I understand that if the person or organization that I authorize to receive my protected health information is not subject to federal and state health information privacy laws, subsequent disclosure by such person or organization may not be protected by those laws.

1. I authorize the following person and /or organization to receive my protected health information.

   Physical Therapy Associates, INC____

   ____

   ____

2. I authorize the following person and/or organization to disclose my protected health Information, as directed to the person and/or organization listed above, at their own expense.

   Physical Therapy Associates, INC____

   ____

   ____

3. Specific description of the protected health information that I authorize for disclosure:

   ____

   ____

4. Purpose for each use or disclosure: Patient Care

5. I understand that I may revoke this authorization In Writing at any time, except to the extent that the person and/or organization named above have taken action reliance on this organization.

6. This authorization expires ____.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction.

____ Signature

_________________________ Birth Date

____ Social Security Number

_________________________ Date