ATLAS THERAPY
SPECIALIZED PHYSICAL THERAPY

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AUTHORIZATION TO USE
OR DISCLOSE MEDICAL INFORMATION

I hereby authorize Atlas Therapy to use and disclose my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that once this information is released to the Designated Party(ies) named below, the released information may no longer be protected by federal privacy regulations, and that it may be re-disclosed by the recipient.

Patient Name: _____ **Birthdate:** _____

Organization Providing the Information: **Atlas Therapy, Specialized Physical Therapy**

Designated Party: _____ Relationship to Patient:_____

Address:_____

Phone: _____ Fax: _____

Specific Description of Information Disclosed:_____
_____
_____

Purpose of Disclosure:_____
_____
_____

The information will be used or disclosed for the following purposes:
[ ] At the request of the individual [ ] Other: _____

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will: (***Must check one***)
   [ ] expire on _____ /_____/____(MM/DD/YEAR)
   [ ] expire 1 year from the date signed by the patient or patient's representative; or
   [ ] be effective for the lifetime of the patient unless revoked (see #2 below)

2. I understand that I may revoke this authorization at any time by notifying **Atlas Therapy** in writing; however, if I do revoke the authorization, it will not have any affect on any actions taken by **Atlas Therapy** prior to their receipt of the revocation.

3. I understand that my treatment cannot be conditioned on whether or not I sign this Authorization.

_____ _____
Signature of patient or patient's representative **Date**
(*Form **MUST** be completed before signing or will not be valid)*

Printed Name of Patient's Representative:_____Relationship to Patient: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION