Authorization for Access, Disclosure of Protected Health Information

CLIENT (PATIENT) INFORMATION

Last_____First_____MI_____

Street_____City_____State_____Zip_____

Date of Birth: _____Telephone Number: _____

Choose One

☐ I authorize Body Balance and Beyond to release information from my "Protected Health Information" any medical claims and billing to the following individual.

☐ I withdraw my authorization to release information from my "Protected Health Information" including any medical claims and billing to the following individual.

Your Designated Individual's:

Last_____First_____MI_____

Street_____City_____State_____Zip_____

Date of Birth: _____Telephone Number: _____

Relationship to Yourself: _____

I authorize the release of this information to the person named above for the following period of time:

From: _____ / _____ / _____ To: _____ / _____ / _____

I have read and understand the following statements:

- I understand this Authorization will expire 60 days after I sign this form.

- I understand that I may revoke this Authorization at any time by notifying the Body Balance and Beyond Compliance Officer in writing, but if I do, it will not have any effect on any actions Body Balance and Beyond took before it received the revocation.

- I understand that there is potential for information disclosed based on this authorization to be subject to re- disclosure by the recipient and no longer be protected by the Privacy Rule.

Patient's Name: _____

Patient's Signature:_____ Date: _____

Designated Individual's Signature:_____ Date: _____