Patient Authorization for Practice to Obtain or Release Protected Health Information

This Authorization for the use and/or disclosure of the specific personally identifiable health information set forth in this Authorization is made pursuant to the requirements of 45 CFR §164.508, which sets out the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 and authorizes Heights Physical Therapy LLC and Heights Performance LLC (the "Practice") to obtain, use and disclose the personally identifiable health information specifically referenced in this Authorization.

Please read the following information carefully:

I, the undersigned, authorize the use and/or disclosure of personally identifiable health information about me as described below:

1. I authorize the following person(s) or class of persons to use and/or disclose the information:

   _____

2. I authorize the following person(s) or class of persons to receive the information:

   _____

3. The following is a description of the information that I authorize to be used and/or disclosed:

   _____

   _____

   _____

4. The information will be used and/or disclosed only for the following purposes:

   _____

   _____

   _____

5. I understand and acknowledge that if the person or entity that receives the information is not a health care provider, health plan, or other entity covered by the federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

6. **(If applicable)** I understand that the Practice will receive compensation for its use and/or disclosure of the information.

7. I understand and acknowledge that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I understand that I may inspect or copy any information used and/or disclosed under this Authorization.

8. I understand and acknowledge that I may revoke this Authorization at any time by sending a written revocation to the Practice at the following address: 718 N. Main St. Unit # 18 Gunnison, CO 81230, Attention: Compliance Officer. However, I also understand and acknowledge that if I revoke this Authorization, my revocation will not be effective to the extent that the Practice has already acted in reliance on this Authorization.

9. This Authorization expires _____ (insert applicable date or event).

I understand all of the provisions in this Authorization, and I wish to execute this Authorization thereby authorizing the use and/or disclosure of the information described above for the purposes described above.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED THIS AUTHORIZATION AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR THE PURPOSES SET FORTH WITHIN THIS AUTHORIZATION

_____ _____

Signature of Patient or Representative Date

_____

Patient's Name

_____

Date of Birth

_____

Social Security Number

_____ _____

Name of Personal Representative (if applicable) Relationship to Patient

A copy of the completed and signed Authorization form has been provided to the patient or representative:

_____Yes _____No

_____ _____

Signature of Authorized Practice Representative Date