Fitzy Health & Wellness

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Certified Rolfer®

# Client Authorization Form

## for Use and Disclosure of Protected Health Information

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I authorize (Fitzy Health & Wellness) to use and/or disclose certain protected health information (PHI).

A. This authorization permits (Name of Practice) to use and/or disclose the following individually identifiable health information about me (specify date, type of service, type of info, etc.):

_____

_____

_____

_____

B. This authorization is effective from (Date)_____ until (Date)_____ or for all past, present and future periods.

C. The information will be used or disclosed for the following purpose:

_____

_____

_____

_____

D. Exceptions to this authorization:

_____

_____

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Client or Legal Guardian

_____

Print Client's Name Date_____

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Print Name of Legal Guardian, if applicable

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