**HIPPA Release Form**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give my permission for Bodyworx Physical Therapy & Chiropractic Wellness Center PLLC, to share my health information and disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions that are related to treatment within this office.

**Form of Disclosure:** I authorize my provider to use the form that is most appropriate and timely.

**Reason for Disclosure:** I understand that Bodyworx Physical Therapy & Chiropractic Wellness Center PLLC will only share the information required/necessary to treat/refer/reimburse my care to the appropriate provider or payer. I hereby grant permission and authorize my information to be released as appropriate for my care in this office.

**Duration of Authorization:** This authorization to share my health information is valid for all current, past, and future episodes or until otherwise requested by me.
I understand that I would need to contact the following to cease the authorization of release:
 Brad Profitt, DC, PT, DPT, DScPT (Privacy officer)
 Bodyworx Physical Therapy & Chiropractic Wellness Center PLLC
 1451 Diederich Blvd., Russell, Ky 41169

I understand that:

* If my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
* No further authorization or further permission for my information release is needed.
* Failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatment or benefits or to pay for the services I receive.
* They may leave voice mails, or send text messages to notify me of healthcare related information or appointment reminders.

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Signature Date
( ) I am the legal guardian of the referenced patient and have legal rights to sign this form for them.

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Parent/guardian printed name Provider