DYNATEST, INC.

HIPAA Privacy Authorization

Authorization for use or disclosure of protected health information

I,_____, give authorization for **Dynatest, Inc.** to release my protected health information regarding appointments, billing, condition, treatment, or prognosis to the following individual(s):

No one_____

Name_____ Relation_____

Name_____ Relation_____

Name_____ Relation_____

Name_____ Relation_____

Use of Protected Health Information

Your protected health information will be used by Dynatest, Inc. for the purposes of treatment, obtaining payment, or supporting the day-to-day healthcare of the patient. By signing this form you acknowledge that any 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.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. Dynatest, Inc. reserves the right to modify the privacy practices outlined in this notice. You may review the notice prior to signing this consent. By signing this consent you acknowledge you have been presented with a copy of Dynatest, Inc.'s Notice of Privacy Practices.

Patient Name:_____(please print)

Patient/Guardian Signature:_____

Date of Signature:_____/_____/_____