AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Core Balance
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Name of Patient: _____ Birthdate: _____
Address: _____ City: _____ State: _____
Phone Number: _____ E-mail: _____

I hereby authorize CORE BALANCE, PLC. to release the following health care records to:

Name/Company Name: _____
Address/Phone #: _____

_____Entire medical records _____Evaluation/Daily notes _____Discuss over phone

The following health information that relates to service beginning from _____ to _____, may be released. I further understand that my medical record may include one or more of the following medical history, treatment record, diagnostic test results, and plans of care.

The above person/organization, its employees, representatives and any other persons performing services for them or on their behalf, may need to obtain, use or disclose any and all information about my physical and mental health, including but not limited to, services for preventative, diagnostic and therapeutic care, tests, counseling, and medical prescriptions for the purpose of continuity of care. I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

This authorization is valid for _____ following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent that CORE BALANCE, PLC. has relied on the use or disclosure of my health information.

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization. I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

_____ _____ _____
Patient's Signature Patient's Name Date

Name of Guardian or Legal Representative: _____ Date: _____

Witness Signature_____Date: _____