

Industrial Physical Therapy, Inc.

AUTHORIZATION TO RELEASE AND/OR RECEIVE CONFIDENTIAL INFORMATION

NAME X	BIRTH DATE X	SOCIAL SECURITY NO. X
ADDRESS X	TELEPHONE X	

TREATMENT AUTHORIZATION

I voluntarily consent to medical care performed by Industrial Physical Therapy, Inc., which may be deemed necessary or advisable. I accept responsibility for charges not covered by insurance. I authorize payment of medical benefits to Industrial Physical Therapy, Inc., agent of Industrial Physical Therapy, Inc., or supplier of services provided on behalf of Industrial Physical Therapy, Inc. I understand services will be provided without discrimination and have read and agree to this Treatment Authorization.

X _____ (Date)	X _____ Signature of Test subject or Authorized Agent/Representative
X _____ Printed Name of Test subject or Authorized Agent/Representative	_____ Authorized Agent/Representative Relationship to Test subject
_____ Address of or Authorized Agent/Representative	_____ Telephone # of Authorized Agent/Representative

This authorization shall be effective immediately from my signature and has no expiration date.

I understand that the records to be used or disclosed pursuant to this authorization may contain information that is subject to special protections pursuant to 42 C.F.R. 164.508 and some state laws. I authorize Provider to use or disclose records containing such information if they are otherwise included within the scope of this authorization by checking the box (es) below:

- Records relating to participation in any federally assisted drug and alcohol abuse program
- Information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition
- Information relating to HIV testing, HIV status, or AIDS

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned Upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records as permitted by law. I understand that I may revoke this authorization at any time by providing a written notice to the designated privacy officer of the provider to whom this authorization is sent. (Note: Revocation is not effective for disclosures that have already been made)

X _____ (Date)	X _____ Signature of Patient or Authorized Agent/Representative
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X _____ Printed Name of Patient or Authorized Agent/Representative	_____ Authorized Agent/Representative Relationship to Test subject
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_____ Address of or Authorized Agent/Representative	_____ Telephone # of Authorized Agent/Representative
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_____ (Date)	_____ Signature of Witness
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