Authorization for Disclosure of Protected Health Information

REVIVAL

THERAPEUTICS AND PERFORMANCE

108 - 120 2nd Ave NE Airdrie, AB T4B 2N2
Info@builtbyrevival.com Tel: 403-945-1530 Fax: 866-720-1055

Patient Name: **Address (including City/Province/Postal code):**	**Date of Birth(dd/mm/yyyy):**
Phone Number:	
Maiden/Previous Names/Nicknames:	

*** fill out form in its entirety. If any section is incomplete, this form may be invalid and the request may not be processed. ***

I hereby authorize Revival Therapeutics & Performance to (circle one):	Disclose my protected health information as indicated below **TO:**
	Obtain my protected health information **FROM:**

Facility/Provider Name:	
Street Address:	**Phone:**
City, Province, Postal code:	**Fax:**

Purpose of Release: (circle)

Continuing Care Personal Transfer of Care Disability Determination

Legal Work Comp Insurance Other

Information to be Released:

Release Method: Mail Fax Secure Email Pick Up: 108-120 2nd Ave NE Airdrie, T4b 2N2
Please list date and time

Service Dates: **From:**_____ **To**: _____

(Circle items below)

Athletic Therapy Notes List of appointments completed Billing Statements

Bioflex Laser notes Exercise Plan Other (Please specify):

Acupunture Notes

I do not want the following information disclosed (as defined by applicable state and federal laws):

Behavioral Health/Mental Health Developmental Disabilities HIV/AIDS Alcohol/Drug Abuse

Genetic Information

This authorization will expire one year from the date of signing unless I indicate an event or earlier date here: _____ YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

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Right to Refuse to Sign This Authorization. I understand that I have the right to refuse to sign this Authorization and Revival Therapeutics & Performance will not condition treatment or payment upon my signing of this Authorization.

Right to Revoke Authorization. I understand that I have the right to revoke this Authorization, except to the extent that Revival Therapeutics & performance has already disclosed my medical information in reliance of Authorization. I understand that my revocation is effective only if it is in writing. To revoke my Authorization I understand that I must send a written request for revocation to Revival Therapeutics & Performances Administration, Attn: Medical Records Supervisor.

Re-disclosure of Information by Recipient. I understand that if my medical information is disclosed pursuant to this Authorization, it may be subject to re-disclosure by the person(s)/organization(s) receiving my medical information and is no longer protected by applicable privacy laws.

Right to Receive a Copy of This Authorization and My Medical Information. I understand that if I agree to sign this Authorization, which I am not required to do, I must be provided with a signed copy of the form. I understand that I also have the right to inspect and receive a copy of the health information I have authorized to be disclosed by this Authorization.

By signing this form I am authorizing Revival Therapeutics & Performance and its affiliates and subsidiaries ("Revival") to disclose my medical information as described in this Authorization

Signature (required):			**Date Signed** (required):	
Printed Name of Person Signing:				
Client is:	Minor	Incompetent	Disabled	Deceased
Legal Authority:	Parent of minor	Legal Guardian	Activated Power of Attorney	Next of Kin