All Star Physical Therapy, Inc.

AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Specific description of information that may be used/disclosed:

   *All individually identifiable health information in the patient's medical record.

2. The information will be used/disclosed for the following purpose(s):

   *To provide appropriate treatment
   *To bill appropriate carrier
   *To share information with referring physician.

3. Persons/organizations authorized to use or disclose the information:

   *All Star Physical Therapy, Inc.

4. Persons/organizations authorized to receive the information:

   *Referring physician
   *Billing company
   *Other_____

5. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, the facility reserves the right to deny that health care.

6. I understand that I may inspect or copy the information used or disclosed.

7. I understand that I may revoke this authorization at any time by notifying the facility in writing, except to the extent that action has been taken in reliance on this authorization.

8. I understand I have a right to request/receive a Notice of Privacy Practices from the facility.

_____ _____
Signature of patient or patient's representative | Date

_____ _____
Printed name of patient or patient's representative | Relationship to patient, or representative's authority to act for the patient, if applicable

A copy of this signed form will be provided to the patient.