



## AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name \_\_\_\_\_

Birthdate \_\_\_\_\_

Social Security # \_\_\_\_\_

1. I authorize the use or disclosure of the above-named individual's protected health information ("PHI") as described in response to Number 3 below;
2. I authorize the following individual or organization to make the disclosure (name and address):

Name \_\_\_\_\_

Address \_\_\_\_\_

3. The type and amount of information to be used or disclosed is as follows (include dates where appropriate):

- Entire record
- Other
- Any PHI relevant to my participation in a physical fitness assessment or exercise program;

4. I understand that the information in my protected health information ("PHI") may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and/or drug abuse;

5. This information may be disclosed to and used by the following individual or organization: **Succeed, LLC**, for the purpose of: my participation in a physical fitness assessment and/or exercise program;

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in sixty (60) days; and

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the above-listed health provider.

*By signing below, I authorize the above-referenced entity to use or disclose my protected health information as described above.*

Signature of Client or Legal Representative \_\_\_\_\_

Date \_\_\_\_\_

If Signed by Legal Representative, Relationship to Patient \_\_\_\_\_

Signature of Witness \_\_\_\_\_