Authorization of Use and Disclosure of Protected Health Information

Health information that Advanced Therapy Solutions collects or receives about you may be disclosed to the following persons:

_____

Name of person/ relation / organization

_____

Name of person / relation / organization

Use and Disclosure of Information:

__ I authorize the person(s) listed above to receive all health information about appointments, treatment and/or other information pertinent to my health care and/or payment for my health care provided at Advanced Therapy Solutions.

__I do not authorize the following information to be disclosed to any other parties except to me as the patient.

_____

Expiration Date of Authorization

This authorization is effective for 1 year after care ends unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate the authorization by submitting a written revocation to Advanced Therapy Solutions. You should contact Dixie Whetsell or an authorized representative to terminate this authorization.

Potential for Re-discloser

The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

_____

Signature

_____ _____

Name of Patient (Print or Type) Signature Date

_____ _____

Signature of Patient Representative Relationship of Patient Representative