Note to Our Patients: Federal and state law allows us to use and disclose information about you for purposes of treatment, billing and receiving payment, and routine health care operations. In order to use or disclose information about you for any other purpose, we need your specific authorization on the form set out below. The "Notice of Patient Privacy Practices" which we provided to you explains how this clinic uses and discloses information. You should read that Notice carefully before signing this authorization form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received or been offered a copy of this office's Notice of Privacy Practices.
{Please Print Name}

_____ _____
{Signature} {Date}

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

I hereby authorize Columbia Gorge Physical Therapy, Inc. to use and disclose health and medical

information about _____
{PRINT name of patient}

Any person listed below has my permission to discuss my health care with representatives of the practice for purposes of treatment, billing and operations.

1. Name_____ Relationship:_____

2. Name_____ Relationship:_____

3. Name_____ Relationship:_____

You have the right to revoke this Authorization at any time, provided that you do so in writing. You can obtain the **"Revocation of Authorization to Use or Disclose Protected Health Information"** from our office manager. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

By: _____ Date: _____
{Patient}

By:_____ Date: _____
{Patient representative}

Description of Representative's Authority: _____

Updated 11/11/14 sb