

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):	
	Acupuncture 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