HIPAA AUTHORIZATION FORM

PATIENT INFORMATION

Patient (Person for whom request is made)____(M Patient")

Patient's Date of Birth:__________ Telephone Number: ______________

Patient's Address: ____

AUTHORIZATION

I authorize Progressive Rehabilitation Solutions, LLC ,("Medical Provider") and its business associates to release the Protected Health Information to the people, groups, or organizations that are listed below:

Any and all people, groups, or organizations that the Medical Provider in its sole and absolute discretion deem advisable for the copyright, use, reuse, and/or publishing and republishing of the photographs taken of the Patient as set forth herein.

I authorize the Medical Provider and its business associates to release:

- O Any and all photographs taken of me in any media print, electronic, or otherwise, whether taken by the Medical Provider or its business associate that may contain or may be construed as containing Protected Health Information.

- O My entire medical file or chart, including, but not limited to, all records in your possession which have been prepared by others, consultations and reports of hospital. doctors, osteopaths and chiropractors, and any other information from health care providers, in connections with their examination, consultations, and/or treatment rendered to me with the exception of drug and alcohol abuse records.

CONSENT AND RELEASE

I hereby give Progressive Rehabilitation Solutions, LLC its legal representative, successors and assigns, the right and permission to copyright and *for* use, reuse, and/or publish and republish, photographic pictures and portraits of me taken by Progressive Rehabilitation Solutions, LLC, or released by the Medical Provider pursuant to this authorization, or in which I may be distorted in character, or form, in conjunction with my own or a fictitious name, on reproductions thereof in color, or black and white, made through any media at the instruction of Progressive Rehabilitation Solutions, LLC its legal representatives, successors and assigns, for the purpose whatsoever, including the use of any printed matter in connection therewith. I hereby waive any right to inspect or approve the finished photograph or advertising copy or printed or electronic matter that may be used in conjunction therewith.

SIGNATURE

I understand that:

- This Authorization is valid for one (1) year from the date of my signature.
- I have the right to cancel this Authorization at any time by completing a hard copy Cancellation of Authorization.
- If the Medical Provider or its business associate has already released my health information, that information will be exempt from my cancellation.
- If the person or entity that receives my health information is not required to comply with the federal privacy regulations, the information would no longer be protected by those regulations.

I understand that the Medical Provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

______________________________ ______________________________

Patient Signature Date

If you have signed the form as a legally-recognized representative of the Patient, please print your name below and your relationship to the Patient that allows you to act on his or her behalf by signing this form.

Name of Representative (please print) ______________________________Relationship: ______________________________

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Medical Provider will obtain a valid, signed authorization from a Patient prior to using or releasing the Patient's Protected Health Information, unless the Patient's authorization is not legally required by law.