The Balanced Body Center

Authorization to use or Disclose Protected health Information

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As required by the Privacy Regulations, The Balanced Body Center may not use or disclose your protected health information except as provided in our Notify of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), and business associates of this office:

Physicians Insight MD's Clinical Interpretation

Patient Health Information authorized to be disclosed: **Thermal Images and related health history**

For the specific purpose of: **Interpretation of said images**

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Receive a copy of this authorization.

_____ _____

Signature of Patient or Patient's Authorized Representative Date

_____ _____

Signature of Authorized Representative-Balanced Body Center Date