NIRVANA SPORTS MEDICINE AND REHABILITATION SERVICES, LLC
NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT AND RELEASE FORM

Disclosure Authorization – For Release of Protected Health Information (PHI)

I have been provided with, read, and fully understand **Nirvana Sports Medicine and Rehabilitation Services, LLC** Notice of Privacy Practices. A copy of the Notice of Privacy Practices is available in the front waiting area or a hard copy may be obtained upon request at any time. I understand that **Nirvana Sports Medicine and Rehabilitation Services, LLC** may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that that **Nirvana Sports Medicine and Rehabilitation Services, LLC** therapists and staff will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in **Nirvana Sports Medicine and Rehabilitation Services, LLC** Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Initials: _______

Communication of Health Information
I give permission to **Nirvana Sports Medicine and Rehabilitation Services, LLC** to disclose and discuss any information related to my medical condition(s) with the following individuals:

Name: ______________________________________ Relationship: ______________________________
Name: ______________________________________ Relationship: ______________________________

Initials: _______

By signing this Authorization Form, I understand that I am giving my authorization to Nirvana Sports Medicine and Rehabilitation Services', LLC designated medical records custodians, database custodians, billing and collections personnel to use and/or disclose my Protected Health Information as described. I further acknowledge and understand that I may revoke this authorization at any time by notifying Nirvana Sports Medicine and Rehabilitation Services, LLC in writing of my intent to revoke this authorization except to the extent that Nirvana Sports Medicine and Rehabilitation Services, LLC has taken action on in reliance to this consent and previously disclosed. Unless revoked earlier, this authorization will expire 180 days after the signing of this authorization form.

____ ____________________________
Signature of Patient or Personal Representative Date

____ ____________________________
Printed Name of Patient Printed Name of Representative