AUTHORIZATION OF USE OR DISCLOSURE OF INFORMATION

I, ____, hereby authorize Advanced Rehabilitation to: (initial all that apply)

______ Treat in an open adjustment/therapy room
______ Send postcards of all occasions
______ List your name in our newsletters
______ Post your picture in our office
______ Use of patient testimonial in reception area
______ Use of patient testimonial on our webpage
______ Use of patient picture in advertisement

This authorization shall be enforced and effective until__________________ at which time this authorization to use or disclose this protected health information expires.

I understand that information used or disclosed pursuant to the authorization, in writing, and any time by sending such written notification to Advanced Rehabilitation at PO Box 203968, Austin, Texas 78720. I understand that a revocation is not effective to the extent that Advanced Rehabilitation has relied on the use of disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Advanced Rehabilitation will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

____
Name of Patient

____ __________________
Signature of Patient or Personal Representative Date

____
Description of Personal Representative's Authority