ergo body

PILATES • PHYSICAL THERAPY • MASSAGE

Consent for release of protected health information (PHI)

Patient information (person whose information will be released):

Name:

Address:

Date of birth: Phone number:

Email:

I understand that this authorization will allow Ergo Body Inc. to use and disclose the protected health information described below:

This information may be disclosed to, and used by, the following person or organization (such as nursing home or care provider) to assist me with the Ergo Body Inc. services for which I am providing consent to disclose information:

Name/Organization:

Address:

Date of birth: Phone number:

Email:

Relationship:

My consent will expire in 24 months unless I cancel it before that time. I can cancel my consent through Ergo Body Inc.

If I cancel consent, it will not apply to any information previously released with this authorization. Once information is shared, Ergo Body Inc. cannot prevent the person or organization that has access to it from sharing that information with others, and this information may not be protected by federal privacy regulations.

I am not required to sign this consent and Ergo Body Inc. cannot base decisions regarding treatment or payment on whether I sign it.

Member or Legal Representative signature:

_____ Date: _____