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HIPAA RELEASE FORM

I, _____, give permission to *More Than A Gym* to:

- use the following protected health information, and/or
- disclose the following protected health information to:

_____
[Name(s) of entity to receive information]

Information to be disclosed (check all that apply):
_ Medical Records
_ Treatment Records
_ Diagnostic Records
_ Other: _____

This protected health information is being used or disclosed for the following purposes:
_____

This authorization expires _____
[specify (1) date or (2) event that relates to the purpose of this use or disclosure].

- If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may bedisclosed to other individuals or institutions and no longer protected by theseregulations.
- You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.
- You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial,your right to access is suspended until the clinical trial is completed.
- You may revoke this authorization in writing at any time by sending writtennotification to *More Than A Gym* at 40 Oak Drive, Syosset NY 11791. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive yourwritten request to revoke authorization.

_____
Printed Patient Name

_____ _____
Signature of patient or guardian Date