Authorization for Use or Disclosure of Information
for Purposes Requested by Ability Prosthetics & Orthotics

I, _____, hereby authorize Ability Prosthetics & Orthotics to
(check those that apply):
__ use the following protected health information, and/or
__ disclose the following protected health information to

All present and past medical history relating to condition being treated for.

This protected health information is being used or disclosed for the following purposes:
__For both Prosthetic and Orthotic care.

This authorization shall be in force and effect until an **(event that relates to the patient or the purpose of the use or disclosure)** at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Tina Humphreys at abilityofnv.com. I understand that a revocation is not effective to the extent that Ability Prosthetics & Orthotics has relied on the use or 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.

I understand that I have the right to

- Inspect or copy my 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.

Ability Prosthetics & Orthotics will not condition my treatment on whether I provide authorization for the requested use or disclosure, except under the following circumstance:

- When the provision of health care by Ability Prosthetics & Orthotics is solely for the purpose of creating protected health information for disclosure to a third party, when such disclosure is contingent upon my authorization.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to Ability Prosthetics & Orthotics from a third party.]

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority