

Authorization for Use or Disclosure of Information  
For Purposes Requested by ACTION BRACE & PROSTHETIC, INC.

I, \_\_\_\_\_, hereby authorize **Action Brace & Prosthetic, Inc.** to  
(check those that apply):

use the following protected health information, and/or

disclose the following protected health information to ( \_\_\_\_\_ ):

---

(Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.)

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

---

(List specific purposes here.)

This authorization shall be in force and effect until (specify (1) date or (2) 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 (**Action Brace & Prosthetic, Inc.**) at (**5942 W. 71st Street**). I understand that a revocation is not effective to the extent that Action Brace & Prosthetic 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.

**Action Brace & Prosthetic** 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 Action Brace & Prosthetic 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 **Action Brace & Prosthetic, Inc.** from a third party.] (If applicable)

---

Signature of Patient or Personal Representative

---

Date

---

Name of Patient or Personal Representative

---

Description of Personal Representative's Authority