Authorization for Release of Protected Health Information (PHI)

Client Information:
Name: _____
Date of Birth: _____

I authorize the release of my medical records, including intake forms, chart notes, reports, billing statements, and any other Protected Health Information (PHI), to the following third parties:
☐ Attorneys ☐ Healthcare Providers ☐ Insurance Case Managers
☐ Other: _____

Specific Information Being Released:
(Please specify what information is to be released, e.g., medical records, treatment history, billing information, etc.)
_____
_____

Name of Recipient(s):
(Please specify the individual(s) or organization(s) receiving the information)
_____
_____

Purpose of Release:
(Please specify the reason for the release, e.g., legal purposes, treatment coordination, insurance verification, etc.)
_____
_____

Expiration Date or Event:
(Authorization will expire on this date or when this event occurs, whichever comes first. Example: "One year from the date of signature" or "Upon completion of legal proceedings.")
_____

Revocation of Authorization:
I understand that I may revoke this authorization at any time by submitting a written request to Thrive Bodyworks. Revocation will not affect actions taken based on this authorization before the revocation.

Consequences of Refusal to Sign:
I understand that I am not required to sign this authorization, and my refusal will not affect my ability to receive treatment, payment, or healthcare benefits.

Signature of Client (or Legal Representative):
Signature: _____
Date: _____

Legal Representative (if applicable):
Name: _____
Relationship to Client: _____