HIPPA Consent and Authorization for Release of Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Our commitment at Kinetix and Balance Health + Wellness is to serve our customers with professionalism and being sure to protect the privacy and security of all protected health information.

During the course of serving your interests it may be necessary to share information with other health care providers or business associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to acquire medical records or test results (MRIs, X-rays, all imaging reports, blood analysis, Other:_____
- For payment purposes, we transmit requested information with your contracted insurance company.
- During health care operations, we may need a second opinion or to inform others in the practice assisting in your treatment of your condition.

The staff of Kinetix and Balance Health + Wellness is committed to obeying all Federal, State, and Local laws and regulations regarding Privacy Practices. If any other uses or disclosers other than the ones listed above are needed, information will only be released with the written authorization of the patient in question. This written authorization may be revoked at any time by the individual, as provided by law. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or heath care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Kinetix and Balance Health + Wellness with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient signature_____Date:_____

Printed Patient Name:_____