NORTH STAR
manual therapy

PATIENT NAME: ______________________________

DOB: ______________________

I, ______________________________, hereby authorize NORTH STAR MANUAL THERAPY, INC. to disclose my protected health information described below to the following person(s) or entities:

____

____.

The protected health information to be disclosed is specifically described as follows (check all that apply):

- ☐ Appointments/Appointment scheduling
- ☐ Bills/Charges
- ☐ Treatment specifics – findings, results and plan of care
- ☐ Other (please describe): ______________________________
  ____

This authorization is effective until the following date: ______________ .

If no date specified, I understand that I have the right to revoke the authorization, in writing, at any time by sending notice to North Star Manual Therapy, Inc. I understand that the revocation is not effective to the extent that the practice has relied on this authorization in its actions.

______________________________ ______________________

Signature of Patient or Guardian Date

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Relationship to Patient