Written Acknowledgement of FitLife Fitness & Aquatics, Inc.'s Privacy Practices & Authorization to Release Medical Information including specially protected information

Name of Patient	
Date	

I hereby authorize FitLife Fitness & Aquatics, or an authorized representative to disclose information to entities involved in the payment of my claim. This authorization includes the release of information about the following, if included in the medical record: AIDS, HIV-related information or testing, psychiatric disorders, drug treatment and/or alcohol treatment.

(Circle those records, if any, which are not to be released)

A complete 6-page copy of FitLife's HIPAA privacy policy is available upon request. This document includes information regarding how your individually identifiable health information is protected.

I understand that I might be releasing information which is specially protected under provisions of the state and/or federal law. I further understand that I may revoke this authorization at any time except to the extent that the person who is to make the disclosure has already acted in reliance on the authorization. If not revoked earlier, this consent will remain in force for one year, from the date of my signature.

By my signature below, I certify I have read and understand the above information as well as the privacy practices of FitLife Fitness & Aquatics, Inc.

______________________________ _________________________

Patient's Signature Date