**Authorization to Disclose Protected Health Information &**

**Acknowledgment of Receipt of Notice of Privacy Practices**

**Notice of Privacy Practices**

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You will be given a copy along with this consent.

**Use and Disclosure of Your Protected Health Information**

Your protected health information will be used by Impact Health and Performance, LLC or disclosed to others for the purpose of treatment, obtaining payment or supporting the day-to-day health care operations of its medical practice.

**Requesting a Restriction on the Use or Disclosure of Your Information**

You may request a restriction on the use or disclosure of your protected health information. Impact Health and Performance, LLC may or may not agree to restrict the use or disclosure or your protected health information. If Impact health and Performance, LLC agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

**Revocation of Consent**

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

**Reservation of Right to Change Privacy Practices**

Impact Health and Performance reserves the right to modify the privacy practices outlined in the notice.

**Signature**

By my signature on this document, I acknowledge receipt of the Notice of Privacy Practices which has been provided by Impact Health and Performance.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient (Print or Type) Signature of Patient Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient Representative Date Relationship of Patient/Representative to Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Impact Health and Performance Staff