AUTHORIZATION FOR RELEASE OR USE OF PROTECTED HEALTH

INFORMATION TO _VETERAN BENEFITS CENTER_ (the "Consultant")

Name of Patient:	
Date of Birth:	
Social Security Number:	
Phone Number:	
Email Address:	
Street Address:	
City, State, Zip	
ITF EXPIRATION	

1. **Authorization for Use and /or Disclosure.** By my signature below I authorize the TP-Health, Incorporated and its officers, directors and employees (the "**Provider**") to receive, use and disclose my protected health information ("**PHI**") to Consultant and the employees and independent contractors of Consultant for the purpose of performing services on my behalf.

2. **Information to be Used and/or Disclosed.** I authorize the use and disclosure of any and all PHI I provide directly to Provider or which Provider obtains under a separate authorization for release of PHI that I may sign in the future, to allow Consultant to obtain PHI about me from any source other than me. Such PHI includes any and all medical records, including every page thereof, including but not limited to office notes, face sheets, history and physical, consultation notes, inpatient records, outpatient records, emergency room records, all clinical charts, order sheets, progress notes, nurses notes, doctors' orders, treatment plans, admission records, discharge summaries, requests for and reports of consultations, correspondence, test results, statements, questionnaires and histories, photographs, imagining including CT scans, MRIs, X-rays, sonograms, videotapes, telephone messages, billing records, pharmacy/prescription records, etc.

3. **Consent to Release and Use of Specially Protected PHI.** I understand that my express consent is required to authorize the use or disclosure of certain records, including information related to testing, diagnosis and/or treatment for HIV (the AIDS virus), sexually transmitted diseases, psychiatric, psychological or mental health disorders or treatment, or drug and/or alcohol use and treatment. I understand that the information to be used or disclosed pursuant to this authorization may include such information. By my separate signature affixed here, I confirm that this authorization is effective as to such records and PHI and I authorize the use and disclosure of this type of information.

4. **Term of Authorization and Right to Revoke.** This authorization shall be valid until the following time until there is a final determination of my Disability Rating and benefits by the VA or until revoked. I understand, in addition, that I have the right to revoke this authorization at any time by a notice delivered to Consultant and Provider in writing, except to the extent that PHI has already been released in reliance upon this authorization.

5. **Acknowledgment of Possibility of Re-disclosure.** I understand that once the information released pursuant to this authorization is received by the recipient, whether Consultant or a third party, it may be re-disclosed and no longer protected under Privacy Laws. I agree to hold Provider its directors, officers and employees harmless from any claim for damages that may occur thereby.

6. **Copies As Effective as Original.** Any facsimile, copy or photocopy of this authorization shall be as effective and enforceable as the original.

7. **Authorization Not A Requirement of Services.** I sign this Authorization voluntarily and I understand that signing this authorization is not required.

8. **Consent**: I give my consent to TP-Health and affiliates to contact me via text message and email.

AUTHORIZATION AND AGREEMENTCONFIRMED BY SIGNATURE BELOW:

_____ _____

Signature of Client/Patient or Legally Authorized Representative Date

If signed by Legal Representative:

_____ _____

Print Name of Legally Authorized Representative Relationship to Patient or Legal Authority of Representative