properly aligned

Disclosure Request & Consent Form

I understand that my health information is private and that use of my health information must be consistent with the *Notice of Privacy Practices*. I further understand that certain disclosures of my health information may only be provided by my written consent. I therefore make the following request, and understand I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

Name: I, _____ Date of Birth: _____

was a client of *Properly Aligned* and last seen on *(date)* _____

request or authorize Properly Aligned to disclose to: *(Practitioner)* _____

the following information: _____

for the purpose of: ☐ Practitioner Change ☐ Supportive Assistance

☐ Team Review of Chart

This consent expires automatically upon the following date, event or condition:

I consent to care, share information and provide payment when requested. Properly Aligned is not responsible unreached goals or adverse reactions. I will contact Properly Aligned and my Physician if I experience any change in health status.

Client Signature: _____ Date: _____

Distribution: Client File, Client

Initials _____Date_____

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