I, , hereby authorize the use or disclosure of my protected health information as described below:

1. **AUTHORIZED PERSONS TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION**

 is authorized to disclose the following protected health information to Jennifer Fox, PT, CDRS of Drive Rehab Services.

1. **DESCRIPTION OF INFORMATION TO BE DISCLOSED**

The health information that may be disclosed is:

History & Physical within the last year [ ]  Current Medication List [ ]  Vision information [ ]

1. **PURPOSE OF THE USE OR DISCLOSURE**

The purpose of this use or disclosure is for Driving or Rehab Services from Drive Rehab Services.

1. **VALIDITY OF AUTHORIZATION FORM**

This Authorization Form is valid beginning on and expires 6 months from this date.

1. **ACKNOWLEDGMENT**

I understand that the information used or disclosed under this Authorization Form may be subject to re-disclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations.

I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Signature: Date: