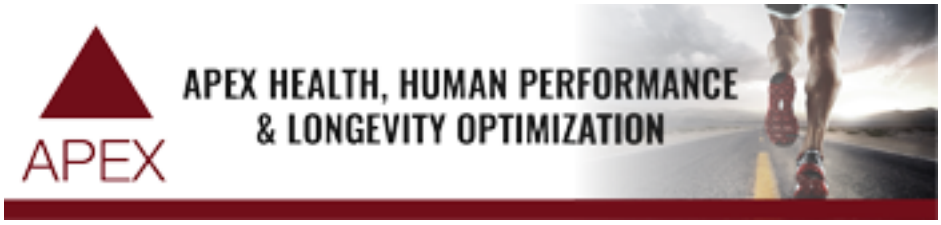

2301 Cedar Springs Road #405, Dallas, TX 75201 ♦ (855) 861- 3820

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Completing this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this Authorization.

Patient Name: _____ Date of Birth: _____

This form is an authorization for APEX Health, Human Performance & Longevity Optimization, a Texas professional limited liability company and their employees, contractors, and agents (individually, and collectively, the "**Practice**") to use my protected health information ("**PHI**") as defined in this Authorization to enable APEX to integrate this information with APEX testing to optimize your medical care.

Authorization Regarding Protected Health Information

_____ [**Patient Initials**] I hereby authorize the Practice to disclose my PHI verbally, by mail, fax or email, to the following person(s).

Name	
Address	
Phone	
Fax	

Purpose of Disclosure: The purpose of the requested use or disclosure is as follows (check applicable categories):

☐ Patient Request
☐ Service Provider Request (Specify):
☐ Other (Specify):

Information to Be Used or Exchanged:

☐ All health information pertaining to my medical history, mental or physical condition and treatment received; or

- ☐ Only the specific records or types of information checked below:
- ☐ Office Visits _____ to _____ (dates)
- ☐ Lab Results _____ to _____ (dates)
- ☐ Diagnosis

☐ Medication History/Current Medications
☐ Results of Psychological Tests
☐ Other (Specify: _____)

Limitations (Specify):

☐ Release of information requiring specific consent. The following categories of information may be included in your medical record, and WILL NOT be released unless you indicate your specific authorization by INITIALING each appropriate category.

	Abortion		Genetic Testing
	Alcohol/Drug Abuse		HIV/ADIS Results/Treatment
	Behavioral/Mental Health		Rape/Sexual Assault
	Domestic Violence		Sexually Transmitted Diseases

Expiration Date of Authorization: This Authorization automatically expires three hundred and sixty (360) days from the date set forth in the signature box, unless otherwise specified by me as follows:

My Rights With Respect to This Authorization: I understand that I have the following rights with respect to this Authorization.

- I may refuse to sign this Authorization as it is strictly voluntary. The Practice has not conditioned provision of services to or treatment of me upon receipt of this signed authorization. My refusal will not affect my ability to obtain treatment, or payment, or eligibility for benefits unless: (i) my treatment is related to research and then I will not be permitted to have treatment without signing this Authorization or (ii) if/when I am receiving health care solely for the purpose of creating information for disclosure to a third party and then I may not receive care unless I sign the Authorization.

- If I do not sign this form, my healthcare and the payment for my healthcare will not be affected.
- I may revoke this Authorization at any time by putting my revocation in writing and delivering a copy in person or mailing it to the Practice at the above address (attention: Privacy Official). This Authorization will be revoked effective upon receipt of such written revocation by Practice's Privacy Official.
- My revocation will not affect actions taken prior to the Practice receiving the revocation.
- I may inspect or obtain a copy of my PHI, if I ask for it.
- I may have a copy of this Authorization after I sign it.

A copy of this signed, dated Authorization shall be as effective as the original.

I understand that information disclosed pursuant to this Authorization could be redisclosed by the recipient. Such re-disclosure is in some cases not prohibited by state or federal law; although, depending on the circumstances, the law may either allow or further limit such re-disclosure.

I have been given an opportunity to ask questions.

Signature of Patient/Parent/Guardian/Personal Representative	
Name (First, Last)	
Name and capacity to sign if other than Patient	
Date	
Home phone	
Cell phone	
Email	
Address	