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Brian Thomson, MD  
Amanda D. Martin, DO  
Brian D. Dierckman, MD  
Elliott J. Kim, MD  
John M. Weldy, MD

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Authorized Recipient (Who May Receive PHI)**

Name/Entity: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax/Email (optional): \_\_\_\_\_

**Authorized to Disclose (Covered Entity/Provider)**

- ☐ Elite Sports Medicine + Orthopedics, PLC  
☐ MPOWER Physical Therapy

**Description of Information to Be Disclosed**

- ☐ Medical History ☐ Treatment Records ☐ Lab/Imaging Results ☐ Imaging Disc  
☐ Billing/Claims Info ☐ Other: \_\_\_\_\_  
☐ Period: From \_\_\_\_\_ to \_\_\_\_\_ ☐ All past, present, future records

**Purpose of Disclosure**

- ☐ Continuity of Care ☐ Legal/Attorney Purposes ☐ Insurance/Claims  
☐ Personal Use ☐ Other: \_\_\_\_\_

(If none selected, "At the request of the individual.")

This authorization expires on: \_\_\_\_\_ OR upon event: \_\_\_\_\_  
(Date) (such as one year from date of signature)

**Patient Rights & Authorization**

- I understand that I may refuse to authorize the release of any of my protected health information and that my refusal will prevent the disclosures of such information but will not affect the healthcare services I currently receive or will receive from the practice.
- I understand that I have the right to revoke this authorization at any time by sending a written notification to the practice.
- I understand that revocation will not affect any disclosures made prior to the receipt of the revocation.
- I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA

\_\_\_\_\_  
Patient/Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

\_\_\_\_\_  
Relationship/Authority

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HIPAA AUTHORIZATION REVISED  
JANUARY 2026