SENSORY THERAPEUTICS INC
210 Jupiter Lakes Blvd. # 4201 Jupiter, FL 33458
(561) 745-0028 Fax (561) 745-0833

AUTHORIZATION FOR THE USE & DISCLOSURE OF HEALTH INFORMATION

Specific Information Requested:_______________________________________

Persons authorized to (use or disclose) or to (receive) the requested information:_______________________________________

Date of Request: ______________________ **Pt. DOB:**_________________

Patient's Name:_______________________________________

Pt's Address:_______________________________________

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Fax Number:___________________ **Office Number:**___________________

Address:_______________________________________

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Signature of Patient or Patient's Representative

____
Printed Name of Patient or Patient's Representative

I hereby authorize Sensory Therapeutics Inc. to disclose my individually identifiable health information as described above. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations. I understand that I may inspect or copy the information disclosed. I understand that I may revoke this Authorization at any time by notifying Sensory Therapeutics Inc. in writing, except to the extent that: (a) action has been taken in reliance on this authorization; or (b) if this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy. This authorization expires on (upon)__________________________.