Universal Coaching Services L.L.C.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, DOB _____,

authorize the following provider(s): _____

_____

to release information to Universal Coaching Services, L.L.C., 1025 Gateway Blvd, #303 #179, Boynton Beach, Florida 33426, Telephone: (561)634-0463, for the purposes of coordinating coaching services with my health care provider(s).

The information to be released is (check all that apply):

____ Most recent visit	____ Last 3 Months	____ Last 6 Months
____ Laboratory reports	____ History and Physical	____ Imaging reports
____ Physician progress notes	____ Medication lists	____ Mental health records

Other _____

I understand that the information in my health care records may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), behavioral and mental health, alcohol or drug abuse or any such related information.

I understand this authorization is strictly voluntary. I understand my treatment, payment, enrollment, coaching, or eligibility for any benefits may not be conditioned on signing this authorization. I further understand that Universal Coaching Services is not responsible for any charges incurred by this request and that I may be required to pay for copies of the records requested pursuant to this form.

I understand that this authorization will be valid for one year from the date signed unless otherwise stated below.

This Authorization expires on: _____.

I understand that information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal privacy regulations. Release of this information may be in several different forms, including verbal, written, audio, or electronic media.

_____	_____	_____
Patient (Print)	Signature	Date