AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

By signing below, I hereby authorize National Seating & Mobility, Inc. (the "Health Care Provider") to use or disclose certain individually identifiable health information (the "Information") as provided in this Authorization.

Information To Be Used Or Disclosed

Patient Name: _____ Identifier: _____

Description of Information: _____

_____

_____

Persons Or Organizations Authorized To Use Or Disclose The Information

I authorize the Health Care Provider and its employees and agents to use or disclose the Information as provided in this Authorization. I understand that I am not required to sign this Authorization. The Health Care Provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this Authorization.

Persons or Organizations Authorized to Receive the Information

_____

_____

Purpose of the Requested Use or Disclosure

_____

_____

Expiration and Revocation of This Authorization

Expiration Date or Event: _____

I understand that I may revoke this Authorization at any time prior to the expiration date or event, but that my revocation will not have any affect on actions taken by the Health Care Provider, its employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to:

_____

_____

_____

I understand that I may see and copy the Information if I ask for it. I understand that the Information may be subject to disclosure by the recipient, if any, and may no longer be protected by federal privacy regulations. I understand that this Authorization does not limit the Health Care Provider's or its employees' or agents' ability to use or disclose the Information for treatment, payment or health care operations or as otherwise permitted by law.

_____ _____

Signature (Patient) Date Signature (Authorized Representative) Date

_____ _____

Signature (Witness) Relationship to Patient

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

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INSTRUCTIONS

This Authorization is intended to comply with the Standards for Individually Identifiable Health Information, 45 C.F.R. Parts 160 and 164 (the "Privacy Standards"). However, it is not intended to be used when treatment, payment, enrollment or eligibility for benefits may be conditioned on the provision of the Authorization, nor is it intended to permit uses or disclosures of psychotherapy notes or for marketing purposes where the marketing is expected to result in direct or indirect remuneration to the Health Care Provider from a third party.

Information To Be Used Or Disclosed.

Patient Name: Insert the name of the individual who is the subject of the health information to be used or disclosed.

Patient Identifier: Insert the identifier used by the Health Care Provider to identify the patient (*e.g.,* the patient's account number). Note that this field is not required by the Privacy Standards, but is for administrative convenience only.

Description of Information: Describe the information to be used or disclosed in a way that identifies the information in a specific and meaningful fashion. For example, "laboratory results from July 1998", "all laboratory results", "the entire medical record" or "all health information" would be acceptable descriptions depending on the amount of information to be used or disclosed.

Persons or Organizations Authorized to Use or Disclose the Information.

Insert the name of the Health Care Provider authorized to use or disclose the information. Note that the authorization extends to the Health Care Provider's employees and agents.

Persons or Organizations Authorized to Receive the Information.

Insert the name or other specific identification of the person(s), or class of persons, to whom the Health Care Provider may disclose the information. Identify these persons with sufficient specificity to reasonably identify the authorized recipient of the information. Note that this field should be left blank where the authorization contemplates only the use of the information by the Health Care Provider.

Purpose of the Requested Use or Disclosure.

Describe each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose

Expiration and Revocation of This Authorization.

Expiration Date or Event: Insert the expiration date of the Authorization, or describe an expiration event that relates to the patient or the purpose of the use or disclosure. This expiration date or event must either be a specific date (*e.g.*, January 1, 2001), a specific time period (*e.g.*, one date from the date of signature) or an event directly related to the patient or the purpose of the use or disclosure (*e.g.*, for the duration of a research project). Note that the following statements or similar language are sufficient if the authorization is for use or disclosure for a research project: (a) "end of the research study"; and (b) if the authorization is for the purpose of creating or maintaining a research database or information repository, "none".

Address for Notice of Revocation: Insert the address of the Health Care Provider where the individual can send written notice of revocation.

Signatures and Copies

This Authorization must be signed and dated by the patient or the patient's personal representative. A personal representative is a person authorized under applicable law to act on behalf of the patient in making decisions related to health care (*e.g.,* a parent or the holder of a power of attorney). If this Authorization is signed by a personal representative, the representative must indicate his or her authority to act for the patient.

If this Authorization is initiated by the Health Care Provider, a copy of this signed Authorization must be provided to the individual.