Patient Authorization for Practice to Release Protected Health Information to Third Parties

Exhibit 6

By signing this authorization, I authorize One to One Physical Therapy, Inc. to use/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits One to One Physical Therapy, Inc. to use or disclose to _____, the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.)

_____

_____

_____

This authorization will expire on _____ (expiration date or defined event).

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that One to One Physical Therapy, Inc. has acted in reliance upon this authorization. My written revocation must be submitted to One to One Physical Therapy, Inc.'s Privacy Officer at 13550 Jog Rd, Suite 100, Delray Beach, FL 33446.

x _____

SIGNATURE of Patient or Legal Guardian Date

x _____

PRINT Name of Patient

x _____

PRINT Name of Legal Guardian (if applicable) Relationship to Patient