Smooth Moves Physical Therapy

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Smooth Moves Physical Therapy to use and disclose protected health information (PHI) about me to carry out treatment and health care operations. My signature confirms that I have been informed of my rights to privacy regarding my PHI, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Conduct normal health care operations such as quality assessment and improvement activities
- Assist in seeking reimbursement from third-party payers for my healthcare services

I have been given the right to review and receive a copy of Smooth Moves Physical Therapy's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. Smooth Moves Physical Therapy reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Ellen Roth PT. I have the right to request in writing that Smooth Moves Physical Therapy restrict how it uses or discloses my PHI to carry out treatment, payment, or health care operations. Smooth Moves Physical Therapy is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

With this consent, Smooth Moves Physical Therapy may call, email, or mail to my home or other alternative location in reference to any items that assist in carrying out treatment, payment, or health care operations, such as appointment reminders and any information pertaining to my clinical care.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Smooth Moves Physical Therapy may decline to provide treatment to me.

Signed by _____ _____ _____

Signature of Patient or Legal Guardian | Date | Relationship to Patient

_____ _____

Print Patient's Name | Print Name of Legal Guardian, if applicable

I give my permission for the following individuals to request treatment or account information:

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