RIVERSIDE PHYSICAL THERAPY CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Patient Name: ____________________________________ Birth Date: ____/____/____
MM/ DD / YR

Address: ____

____

Home Telephone Number: ______________________ E-mail: _____________________________

Work Telephone Number: ______________________

Patient Identification Number and/or Social Security Number: ____________________

1. Permission to Use and Disclose Your Health Information. By signing this consent, you authorize us to use and/or disclose your health information for treatment, payment or health care operations. You have the right not to sign this consent. However, if you refuse to sign this consent, we have the right to refuse to treat you.

2. Your Rights With Respect to This Consent.

2.1. Right to Review Notice of Privacy Practices. We have provided you, along with this consent form, a copy of our Notice of Privacy Practices which details how we may use and disclose your health information. You have the right to review this Notice before signing this consent. We may amend the Notice from time to time. You may obtain a copy of our Notice of Privacy Practices, including any revisions we have made by contacting ***The Office Manager at Riverside Physical Therapy.***

2.2. Right to Request Restrictions on Use/Disclosure. You have the right to request that we restrict how we use and/or disclose your protected health information for the purpose of providing treatment, obtaining payment for our services, and/or conducting health care operations. Such requests must be made in writing. Please note that we are not *required* to agree to any restriction you may request. If, however, we decide to agree to a restriction you have requested, we must restrict our use and/or disclosure of your health information in the manner described in your request. To obtain a restriction request form, please contact ***The Office Manager at Riverside Physical Therapy.***

2.3. Right to Revoke Consent. You have the right to revoke this consent at any time. Your revocation of this consent must be in writing. If you wish to revoke this consent, please contact ***The Office Manager at Riverside Physical Therapy*** to obtain a revocation form. Note that your revocation of this consent will not be effective for disclosures we have already made in reliance on your prior consent. We also have the right to refuse to provide further treatment if you revoke this consent.

2.4 Right to Receive a Copy of This Consent Form. You have a right to receive a copy of this consent form after you sign it.

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3. Effective Period. This consent is effective unless and until you revoke it in writing.
4. I hereby authorize Riverside Physical Therapy.
   to use and/or disclose my health information for treatment, payment, or health care operations.

____ _____/_____/_____

Patient Signature Date

If Patient is unable to sign, complete the following:
Patient is unable to sign because: ____

____

Name of Personal Representative: ____

Relationship to Patient: ____

Authority of Personal Representative (*e.g.,* health care power of attorney, guardian, other statutory authorization): ____

Address: ____

____

Home Telephone Number: ____

Work Telephone Number: ________________________ E-mail: ________________________

____ ____/_____/_____

Signature of Personal Representative Date