# Community Rehab Physical Therapy

**PATIENTCONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)**

I hereby give my consent for Community Rehab Physical Therapy to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The "Notice of Privacy Practices" provided describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Community Rehab 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 Community Rehab Physical Therapy

With this consent, Community Rehab Physical Therapy may call my home or other alternative location and leave a message on the answer machine, voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory tests results, among others.

With this consent, Community Rehab Physical Therapy may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment and healthcare operations (TPO) such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Community Rehab Physical Therapy may e-mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment and healthcare operations (TPO), such as appointment card reminders and patient statements. I have the right to request that Community Rehab Physical Therapy restrict how it uses or discloses my private healthcare information (PHI) to carry out treatment, payment and healthcare operations (TPO). The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting Community Rehab Physical Therapy to use and disclose my private healthcare information (PHI) to carry out treatment, payment and healthcare operations (TPO). 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, Community Rehab Physical Therapy may decline to provide treatment to me.

MAY WE LEAVE MESSAGES ON YOUR HOME TELEPHONE FOR THE FOLLOWING REASONS (Referral appointments with specialists; appointments for tests, medicine refills, follow-up appointments with our office)? _____Yes _____No

IF NOT, HOW MAY WE CONTACT YOU?_____
_____

WHO IN YOUR FAMILY MAY REQUEST HEALTH INFORMATION ABOUT YOU ( i.e. test results, appointments, referrals, medication information, general medical information including diagnoses):
_____
_____
_____
_____
(If you want only limited information given to any specific person please note what type information you are allowing to be given.)

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Print Patient's Name Print Name of Legal Guardian (if applicable)