PATIENT INFORMATION RELASE FORM

According to the Health Insurance Portability and Accountability Act, known as HIPAA, physical, occupational and speech therapists in private practices must incorporate the federal privacy standards to protect patient's medical records and other health information provided to health plans, doctors, hospitals and other health care providers. Please note that your personal health information may be used by **FUSION Physical Therapy, Inc.** for treatment, obtaining payment, during an audit, in emergencies, or when required by law. You will be asked for written authorization to use your personal medical information for any other reason than those listed above. You have the right to review your personal health information at any time, to request that inaccurate information be corrected, or to request a list of instances when the information has been disclosed for reasons other than treatment, payment or other administrative purposes. You have the right to restrict how the information is used and disclosed for treatment, payment and administrative operations. The requests for restrictions will be considered on a case-by-case basis. You have the right to address concerns and complaints about a potential violation of your health privacy to the US Department of Health and Human Services.

For further questions, you may contact the Compliance Officer, Mary Smith, at the address or number below.

I have read and fully understand **FUSION Physical Therapy, Inc**. Notice of Information Practices. I understand that **FUSION Physical Therapy, Inc**. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluation the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the **FUSION Physical Therapy, Inc**. office in writing. I also understand that **FUSION Physical Therapy, Inc**. will consider requests for restrictions on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in **FUSION Physical Therapy, Inc**. Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying **FUSION Physical Therapy, Inc**. in writing at any time.

Print Name: _____ Date: _____

Signature: _____

Patient Privacy Notice

It is our policy to not release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recoded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone. If you would like to have information released to someone other than yourself please complete the following:

I, _____ hereby authorize **FUSION Physical Therapy's** staff to leave medical information pertaining to my care by telephone, email, or voicemail and will assume responsibility to notify them whenever this information changes.

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