Spine and Sport Physical Therapy P.C.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME:_____

ADDRESS:_____

TELEPHONE:_____

SOCIAL SECURITY NUMBER:_____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

Spine and Sport Physical Therapy

PHONE: (208) 359-6127 FAX: (208) 359-9479

217 N 2ND E, REXBURG, ID 83440

RIGHT TO REVOKE: You will have the right to revoke the Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, HAVE HAD A FULL OPPORTUNITY TO READ & CONSIDER THE CONTENTS OF THIS CONSENT FORM & YOUR NOTICE OF PRIVACY POLICIES. I UNDERSTAND, BY SIGNING THIS FORM, I AM GIVING CONSENT TO YOUR USE & DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES AND HEALTH CARE OPERATIONS.

SIGNATURE:_____

If a personal representative on behalf of the patient signs this Consent, complete the following:

PERSONAL REPRESENTATIVE'S NAME:-

_____

PERSONAL REPRESANTATIVE'S PHONE NUMBER:_____

PERSONAL REPRESETATIVE'S BILLING ADDRESS (If not the same as above)

_____

_____

RELATIONSHIP TO PATIENT_____