

Healy Physical Therapy & Sports Medicine, Inc.
Consent to the Use and Disclosure of Health Information
for Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, the staff of Healy Physical Therapy & Sports Medicine, Inc. originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I have been provided with a Notice of Information Practices that provide a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices. I understand I have a right to review or request a copy of my records and that I may request that the records be amended. The Practice is not required to agree to the amendments. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing except to the extent that the Practice has already taken action in reliance thereon.

I request the following restriction to the use or disclosure of my health information _____

The practice will not disclose patient information (This includes discussions for treatment, Rx renewals, details of appointments and billing problems among other information) to anyone other than the people listed on the lines below. You must specify each person including non-custodial parents, spouses, guardians and other family members.

IF NO NAMES ARE GIVEN, NO PATIENT INFORMATION WILL BE DISCUSSED WITH ANYONE OTHER THAN THE PATIENT.

Names: _____

Circle one:

Yes No The practice has my permission to call my home number to confirm appointments and may leave a message on my answering machine or with the person answering the phone.

Yes No The practice may contact me at work to reschedule appointments or confirm existing appointments.

Signature of Patient or Legal Representative

Date