



PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand PROACTIVE PHYSICAL THERAPY's Notice of Information Practices. I understand that PROACTIVE PHYSICAL THERAPY may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating 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 practice. I also understand that PROACTIVE PHYSICAL THERAPY will consider requests for restriction 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 PROACTIVE PHYSICAL THERAPY's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name

Signature

Signature of Parent/Guardian
(if patient is a minor)

Date

(OPTIONAL)

I also authorize PROACTIVE PHYSICAL THERAPY to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

Patient Name

Signature

Signature of Parent/Guardian
(if patient is a minor)

Date

