AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient Name
Last: _____ First: _____

Home Address: _____

_____

Home Telephone: _____Date of Birth _____/_____/_____

With my consent, Focus Physical Therapy may use and disclose protected health information(PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Focus Physical Therapy Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Focus Physical Therapy reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Focus Physical Therapy, Privacy Officer, MBAC, 20 Valley Street, Ste. 340, South Orange, NJ 07079.
With my consent, Focus Physical Therapy may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance issues and any calls pertaining to my clinical care, including test results among others.

With my consent, Focus Physical Therapy may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

By signing this form, I am consenting to Focus Physical Therapy's use and disclosure of my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO).

I may revoke my consent in writing to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, Focus Physical Therapy may decline to provide treatment to me.

_____ _____
Signature of Patient or Legal Guardian Patient Name

_____
Date