HIPAA Patient Consent Form

Finger Lakes Physical Therapy P.C.
376 Elmira Rd., Suite 100, Ithaca NY 14850
24 Main Street, Freeville NY 13068
Patient Consent for Use and Disclosure of Protected Health Information

I, or my authorized representative, request that information regarding my care and treatment be released as set forth on this form:

In accordance with the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 I hereby give my consent for **Finger Lakes Physical Therapy** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

The Notice of Privacy Practices provided by **Finger Lakes Physical Therapy** describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Finger Lakes Physical Therapy** reserves the right to revise its Notices of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Finger Lakes Physical Therapy**.

With this consent, **the practice of Finger Lakes Physical Therapy** may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care.

With this consent, **the practice of Finger Lakes Physical Therapy** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal & Confidential."

With this consent, **the practice of Finger Lakes Physical Therapy** may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **the practice of Finger Lakes Physical Therapy** restrict how it uses or discloses my PHI to carry out TPO. The Practice is not required to agree to my requested restrictions, but if it does, itis bound by this agreement.

By signing this form, I am consenting to allow **the practice of Finger Lakes Physical Therapy** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **the practice of Finger Lakes Physical Therapy** may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

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Print Name of Parent/Legal Guardian, if applicable