Healthy Body Physical Therapy

Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

2. Obtain payment from third party payers.

3. Conduct normal healthcare operations such as quality assessments, research, and physical

I have received, read and understand the Notice of Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact Healthy Body Physical Therapy at any time to address any concerns regarding the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare options. I also understand you are not required to agree to my required restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ________________________________

Patient Signature: ______________________________

Date: ______________