METRO PHYSICAL THERAPY

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct plan and direct my treatment and follow up among multiple healthcare providers who might be involved in that treatment directly and indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have received, read and understand Your Notice of Privacy Practices containing a more description of the uses and disclosures of my health information. I understand that this organization has the rights to change its Notice of Privacy Practices from time to time and that I my contact this organization at any time to obtain a current copy of the Notice of Private Practices

I understand that I might request in writing that you restrict how much private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to obey by such restrictions.

PATIENT NAME:____

RELATIONSHIP TO PATIENT: ____

SIGNIATURE: ____

DATE: ____