VITAL PHYSICAL THERAPY
INTEGRATIVE HANDS-ON THERAPY

Informed Consent

I do hereby agree and give my consent for Vital Physical Therapy to furnish care and treatment that is considered necessary and proper in the diagnosing or treating of my physical condition.

I understand that Vital Physical Therapy will maintain my privacy to the highest standards and 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.

Photographs taken during initial evaluation, progress evaluation and discharge summary will be used for postural comparison purposes and as educational tools. By signing below I consent to the use of these photographs in a professional manner.

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.
I hereby certify that all the above information is true to the best of my knowledge.

*I have had the opportunity to review the "Notice of Health Information Practices" Privacy Notice (**HIPAA** privacy act) prior to signing this consent.*

Patient/Parent/Guardian Signature:_____

Date:_____

Medical Information Release Form

Name: _____ Date of Birth: _____/____/_____

Release of Information
[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:
[ ] Spouse_____
[ ] Child(ren)_____
[ ] Other_____
[ ] Information is not to be released to anyone.

Messages
Please call [ ] my home [ ] my work [ ] my cell Number:_____ If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call