II. USE AND DISCLOSURE OF HEALTH INFORMATION

Pursuant to the requirements found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the following is offered for your information and consent. Please be aware that it is this corporation's policy to require your reading and signing this consent form prior to the provision of treatment or any other medical services. If you have any questions, please ask for the Privacy Officer of this corporation.

I,_____, currently residing at_____of (city)_____, (county) _____(state)_____ do hereby consent to the use and disclosure of my individually identifiable health information ("Health Information") by **Associates In Medical Rehabilitation PA** ("Provider") for the purposes of providing treatment to me, receiving payment from responsible parties for health care services rendered by the Provider, and/or engaging in health care operations, such as office management, credentialing, case management, and quality assessment. This authorizes the release of my Health Information or copies of such to be transferred to myself and/or any physician that I am referred to by a Associates In Medical Rehabilitation PA provider.

I understand that Provider's Notice of Privacy Practices ("Notice") describes in more detail the types of uses of disclosures of Health Information involved in treatment, payment or health care operations, and that I have a right to request and review such Notice prior to signing this consent.

I understand that the Provider has reserved the right to change its privacy practices as described in the Notice. In the event of any change in the Provider's privacy practices, Provider will revise the Notice. I understand that I can obtain a copy of the revised Notice by writing to Provider.

I understand that if I choose to not sign this consent, Provider may withhold medical services, other than emergency services.

I understand that I have the right to request a restriction (ask for and see Patient Authorization to Use/Disclose Health Information) on Provider's use or disclosure of any and/or all Health Information to any and/or all locations, entities, or persons (including family members I wish to have or not have access to my Health Information). I further understand that Provider is not obligated to agree to my request. However, if Provider does agree to my request, the agreement will become binding.

I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that Provider has relied on this consent, and that any revocation will become effective on the date it has been received by Provider and will apply to uses and disclosures of the Health Information after the date of receipt.

Dated this _____day of _____, 20____.

_____

Patient's Signature

If not signed by the patient, please print name & indicate relationship:_____

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OFFICE USE ONLY

Patient requested and received the Notice of Health Information Practices. Date: _____; Initials:_____

Patient requested and filled out restrictions on Patient Authorization to Use/Disclose Health Information form (see chart).