Heights Hand Therapy OT
Hand & Upper Extremity Rehabilitation, PLLC

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PLEASE READ CAREFULLY, THERE ARE 2 PLACES TO SIGN

ACKNOWLEDGMENT OF RECEIPT OF NOTICES OF PRIVACY PRACTICES

I CERTIFY THAT I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY REQUIRED UNDER THE HIPPA REGULATIONS AND I HAVE READ AND UNDERSTAND IT:

* _____ * _____ _____

NAME OF PATIENT (PRINT) SIGNATURE OF PATIENT DATE

_____ _____

SIGNATURE OF PATIENT REPRESENTATIVE RELATIONSHIP

(REQUIRED IF PATIENT IS A MINOR)

PATIENT INFORMATION CONSENT FORM

I have read and understand the Practices' Notice of Patient Information Practices. I understand that the Practice may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and my administrative operations related to treatment or payment.

I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the Practice. I also understand that the Practice will consider requests for restriction of a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in the Practice's Notice of Patient Information Practices. I understand that I retain the right to revoke this consent by notifying the Practice in writing at any time.

* _____ * _____ _____

NAME OF PATIENT (PRINT) SIGNATURE OF PATIENT DATE