INDIVIDUAL PATIENT AUTHORIZATION / ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT NAME:_____**PHONE NUMBER**:__(_____)_____-_____

☐ Check here if address was provided on patient information form at first visit.

I give my authorization to use or disclose my protected health information ("PHI") as described on page one of Aliso Viejo Physical Therapy's Notice of Privacy Practices. I give this authorization voluntarily. I have been offered and/or reviewed a copy of Aliso Viejo Physical Therapy's Notice of Privacy Practices, which describes how my PHI is used and shared. I understand that Aliso Viejo Physical Therapy has the right to change this Notice at any time. I may obtain a current copy by contacting Aliso Viejo Physical Therapy's Privacy official or by visiting the Aliso Viejo Physical Therapy website at alisoviejophysicaltherapy.com

My signature below acknowledges that I have been offered and/or reviewed a copy of the Notice of Privacy Practices, and I have had the chance to read and think about the contents of this authorization form.

_____ _____

Signature of Patient/Personal Representative **Date of Birth**

_____ _____

Print name **Date**

_____

Personal Representative Title
(Parent, Guardian, Executor of Estate, Healthcare Power of Attorney)

This authorization will end seven (7) years from the signature date.
This authorization may be revoked at any time by giving written notice to the Privacy Office at this office. If you are giving this authorization as a condition of obtaining insurance coverage and you revoke this authorization, the insurance company has a right to contest your claims under the policy. In addition, information disclosed under this authorization may be redisclosed by the recipient. Federal privacy rules may not protect the privacy of your health information once the recipient rediscloses it.