

CAMELVIEW PHYSICAL THERAPY

4250 E CAMELBACK RD
PHOENIX, ARIZONA 85018
602-956-9434

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability and 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 the multiple healthcare providers who may be involved in that treatment directly or indirectly.

Obtain payment for third party payers.

Conduct normal healthcare operations such as quality assessments and physical therapist certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the use and disclosure of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent.

I understand that I may request in writing that you restrict how my private health information is used or disclosed and that you are not required to agree to my requested restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Signature of Patient or Legal Guardian: _____

Patient Name: _____

Date: _____