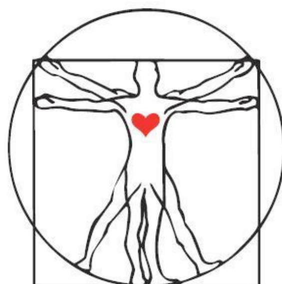

TEMPLE PHYSICAL THERAPY
NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been made aware of Temple Physical Therapy's Privacy Practices and HIPAA regulations which are posted in the reception area. I am aware that if I have any questions or concerns regarding my personal health information I can speak to the Office Supervisor.

I give Temple Physical Therapy (TPT) permission to secure any of my medical records for the purpose of treating me and to communicate with my primary care physician or other referring medical providers involved with managing my medical care. I also agree that TPT can release my medical records to accrediting or regulatory agencies that request my records if the law permits those agencies to access my records. I also give permission to disclose my health information to a designated relative (or any person I identify below) that is directly involved in my health care or who has responsibility for payments. For billing purposes, I authorize TPT or its related entities to release to my insurer any information needed to secure payments related to the medical treatment I receive, as necessary. **In addition to the above the following person(s) may have access to my medical information, if needed:**

1. Name: ____________________________

2. Name: ____________________________

3. Name: ____________________________

If you would like any restrictions to the use of your medical information please request the ***Information Restriction Form*** from front office personnel.

Signature: _____________________________________ **Date:**__________________