

Acknowledgement of Receipt of Notice of Privacy Practices

This acknowledgment form is provided to you as required by the Privacy Rule and related regulations under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA").

I (patient name), _____ have received the Notice of Privacy Practices from PhysioLogic Physical Therapy, PC.

Signature: _____ Date: _____

(If Patient is a: minor or unable)

Name of personal representative (please print): _____

In lieu of patient's signature, I, _____, a staff member of PhysioLogic Physical Therapy, PC, state that _____ has been given out current Notice of Privacy Practices.

x _____ Date: _____

Health Information Release

I (patient name), _____, authorize PhysioLogic Physical Therapy, PC to use and/or disclose Personal Health Information (PHI) about me to the following person (s) and/or entity(ies):

Please list the Name and Relationship to person(s) and entity(ies) below:

Family Member(s) name and relationship: _____

Health Aide: _____

Attorney: _____

Other (name and relationship): _____

(If Patient is a: minor or unable)

Name of personal representative (please print): _____

Signature: _____ Date: _____