



HIPAA Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. West Town PT provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient Understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- West Town PT has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
- West Town PT reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information, but West Town PT does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.

Printed Name

Signature

Date