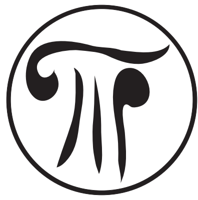

Pillars Physical Therapy
and Wellness Center

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NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Consent and Acknowledgement

The Healthcare Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program which requires that all medical records and other individually identifiable health information used or disclosed by us in any form are kept properly confidential. This gives you the patient, rights to understand and control how your health information is used.

By signing this consent form, I authorize **Pillars Physical Therapy and Wellness Center** to use my protected health information to carry out the following:

- Treatment
- Obtaining payment from third-party payors (insurance companies)
- Day-to-day health care operations of your practice

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or other healthcare operations, but that you are not required to agree to these restrictions.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

I, the undersigned, acknowledge with my signature that I have received a paper copy of the Notice of Information Practices and hereby consent to the use and disclosure of my health information for purposes noted.

______________________	______________________	__________
Patient's Printed Name	Patient's Signature	Date

FOR MINORS

______________________	______________________	__________
Parent's/Guardian's Name	Parent's/Guardian's Signature	Date