AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient Name :_____

Home Telephone: _____ **Date of Birth:** _____

I _____ **give permission to release information to the following family members:**

_____ _____

_____ _____

Relationship to patient **Relationship to patient**

With my consent, AccuCare Physical Therapy and Sports Medicine PA (AccuCare) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the AccuCare Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. AccuCare reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to AccuCare, Attn.: Privacy Officer, at 1610 Route 88 W., Ste. 103, Brick, NJ 08724.

With my consent, AccuCare may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance issues and any call pertaining to my clinical care, including test results among others.

With my consent, AccuCare may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

By signing this form, I am consenting AccuCare's use and disclosure of my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO).

I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, AccuCare may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date