river bend
PHYSICAL THERAPY & PREVENTATIVE CARE

PATIENT INFORMATION AUTHORIZATION FORM

I have fully read and understand RBPTPC's Notice of Information Practices. I understand that RBPTPC may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to the treatment or payment.

I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operation by submitting a written request. I also understand that RBPTPC will consider requests for restrictions on a case-by-case basis.

I hereby authorize the use and disclosure of my personal health information for purposes as noted in RBPTPC's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

PATIENT NAME (PRINT)

PATIENT SIGNATURE OR RESPONSIBLE PARTY

DATE