Chicago Rehabilitation Services, Inc.

Privately Owned and Independent Physical Therapy Center

Release & Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I, ____________________________________ , hereby give my consent to **Chicago Rehabilitation Services, Inc.** to
(Name of Patient or Authorized Agent)
use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of ____________________________________ .
(Patient's Name)

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this Chicago Rehabilitation Services office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this Chicago Rehabilitation Services office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
5. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
6. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the Chicago Rehabilitation Services physical Therapist has the right to refuse to give care.
7. I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physical therapist. I also understand that I will not be able to revoke this consent in cases where the physical therapist has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physical therapist's office.

I acknowledge receipt of the physical therapist's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information. I understand that the physical therapist has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made at the office site. I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_______________________________________ _____________________

Patient Signature Date