PHYSICAL THERAPY
SPECIALISTS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

By signing this form, you will acknowledge that you have had the opportunity to read a copy of Physical Therapy Specialists' Notice of Privacy Practice and consent to the use and disclosure of your protected health information to carry out treatment, payment activities & healthcare operations. You have the right to revoke this consent at any time by providing written notice of your revocation.

DATE ________________________________

PLEASE PRINT PATIENT NAME

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SIGNATURE OF PATIENT, GUARDIAN OR POWER OF ATTORNEY

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