KIRKLAND PHYSICAL THERAPY NOVELTY HILL PHYSICAL THERAPY

CONSENT TO USE AND/OR DISCLOSURE OF PATIENT INFORMATION

As a patient of **Novelty Hill Physical Therapy,** you have the right to know how we may use and disclose information about you. Information about this is provided in our Notice of Patient Privacy Practices.

You have the legal right to review our Notice of Patient Privacy Practices before signing this form. A copy of this Notice was made available to you along with the Consent. If you do not have a copy of the Notice you can request one from us at the address and phone number given below.

We may change our Notice of Privacy Practices from time to time. If we do change it, we will make a copy of the revised Notice available to you the next time you come in for an appointment. You may obtain a copy of our current Notice upon request to our address and phone number given below.

You should read our Notice carefully before signing this form. As our Notice of Privacy Practices explains, we need your consent to use or disclose information about you so that we can provide you with health care treatment; arrange payment for your care; and conduct certain kinds of administrative healthcare operations. By signing this consent below, you agree that we may use or disclose information about you for these purposes.

You have a legal right to request us not to use or disclose information about you for some kinds of treatment, payment or healthcare operations purposes. We are not legally required to grant this kind of request. We are only bound by a request for additional restrictions if we agree to them in writing. Please contact us at the address and phone number given below if you want more information or to request additional restrictions.

You have the right to revoke this consent at any time, but must do so in writing. A revocation of this consent will not apply to any use or disclosure of information, which happened before we received your written revocation. Please contact us at the address and phone number below if you want more information, or to revoke this consent.

By signing below you agree that we may use information about you for purposes of providing treatment, arranging payment, and health care operations.

I am also authorizing Novelty Hill Physical Therapy to leave detailed messages on my answering machine.
_____ (Please initial)

I authorize Novelty Hill Physical Therapy to release or not release information to:
(circle one)

_____
Name/Relationship to Patient

_____
Name of Patient

_____ _____
Patient Signature Date

Practice Name: **Novelty Hill Physical Therapy**
Practice Address: 23515 NE Novelty Hill Rd, Suite B-213
Redmond, WA 98053
Practice Phone: (425) 868-5260
Practice Fax: (425) 868-8604