S.M.A.R.T. Physical Therapy

## PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Federal Government
Health Insurance Portability and Accountability Act of 1999 Regulation

With my consent, SMART Physical Therapy. ("SMART PT") may use and disclose protected health information ("PHI") about me to carry out treatment, payment, and health care operations ("TPO"). Please refer to SMART PT's *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. SMART PT reserves the right to revise its *Notice of Privacy Practices* at any time. A revised *Notice of Privacy Practices* may be obtained by forwarding a written request to the Office Manager at 11 Pleasant St., P.O. Box 1557, New London NH 03257.

By signing this form, I consent that SMART PT may call my home or other designed location and leave a message on voice mail or disclose to a third party (who may answer my phone) any information that assists SMART PT in carrying out TPO, such as appointment reminders, insurance items, or other health care-related communication pertaining to my clinical care.
With my consent, SMART PT may mail my home or other designated location or e-mail to me any items that assist in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked "Personal and Confidential."

I have the right to request that SMART PT restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow SMART PT to use and disclose my PHI to carry out TPO.

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

_____ _____
Signature of Patient or Legal Guardian Date

_____
Patient's Name (please print)

_____
Relationship to Patient (if applicable)

_____
Name of Legal Guardian (if applicable)

SMART Physical Therapy, 11 Pleasant St., New London NH, 03257 Phone: 603-526-7627 Fax 603-676-7967 email: tim@smartptnh.com