

## **RACE TO RECOVERY PHYSICAL THERAPY**

### **PATIENT HIPAA AWARENESS AGREEMENT**

With my permission, Race to Recovery Physical Therapy, P.C. (The Practice) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Race to Recovery Physical Therapy's Notice of Privacy Practices for a more complete description of such uses and disclosures.

A copy of the Notice of Privacy Practices was made available to me prior to signing this consent. The Practice 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 Privacy Officer.

With my permission, the offices of Race to Recovery Physical Therapy may call my home or other designated locations and leave a message on voicemail, or in person, in reference to any items that may assist The Practice in carrying out TPO, such as appointment reminders, insurance matters and any information pertaining to billing/collections or my clinical care, including laboratory results among others.

With my permission, the offices of Race to Recovery Physical Therapy may mail to my home, or other designated location, any items that assist The Practice 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 The Practice restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, though if it does so, is bound by this agreement.

By signing this form, I am allowing Race to Recovery Physical Therapy, P.C. to use and disclose my PHI for 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.

I may make the following special request for confidential communications:

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Signature of Patient or Legal Guardian

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient's name

\_\_\_\_\_  
Print Legal Guardian's name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date