HIPAA PRIVACY

AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION AND ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing. Ground Works Physical Therapy, PLLC will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that nearly all treatment performed at Ground Works Physical Therapy, PLLC is done in an open setting where incidental disclosures may occur. Private consultations are available on request. You also agree that Ground Works Physical Therapy, PLLC may use or disclose your personal health information for referral to other health care providers with your permission, any billing or collection activities or proceedings, leaving messages on answering machines or making phone calls to you regarding scheduling of appointments, your health benefit coverage and related discussion of your care, or phone or mail notifications of any internal office promotions.

Please identify the family members, friends or other persons who are or will be involved in your care or payment for health care and with whom you authorize us to share your protected health information:

Name	Relationship to you	List information to be shared
_____	_____	_____
_____	_____	_____
_____	_____	_____

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Ground Works Physical Therapy's NOTICE OF PRIVACY PRACTICES containing a description of your rights, and permitted uses and disclosures, under HIPAA. While Ground Works Physical Therapy has reserved the right to change the terms of its NOTICE OF PRIVACY PRACTICES, copies of the NOTICE, as amended ,are available from Ground Works Physical Therapy at its office or by sending a written request with return address to 1934 Brooks St. Missoula, MT 59801, Attn: Privacy Officer. You have the right to revoke this authorization, in writing, at any time, except to the extent that Ground Works Physical Therapy has taken action in reliance on it. A revocation is effective upon receipt by Ground Works Physical Therapy of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Ground Works Physical Therapy, or (d) two (2) years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

Acknowledged and agreed to by:

PATIENT NAME: _____

PATIENT SIGNATURE: _____ _____

Print Name _____ Date

Address: _____

OR

REPRESENTATIVE/GUARDIAN: _____ _____

Print Name:_____ Date

Relationship to Patient: _____

Address: _____