



ANDY HOUGUM, P.T. • GARY HOFMANN, P.T.

PATIENT INFORMATION CONSENT FORM

I HAVE READ AND FULLY UNDERSTAND THAT SHASTA PHYSICAL THERAPY NOTICE INFORMATION PRACTICES. I UNDERSTAND THAT SHASTA PHYSICAL THERAPY MAY USE OR DISCLOSE MY PERSONAL HEALTH INFORMATION FOR THE PURPOSES OF CARRYING OUT TREATMENT, OR OBTAINING PAYMENT, EVALUATING THE QUALITY OF SERVICES PROVIDED AND ANY ADMINISTRATIVE OPERATIONS RELATED TO TREATMENT OR PAYMENT. I UNDERSTAND THAT I HAVE A RIGHT TO RESTRICT HOW MY PERSONAL HEALTH INFORMATION IS USED AND DISCLOSED FOR TREATMENT, PAYMENT, AND ADMINISTRATIVE OPERATIONS IF I NOTIFY THE PRACTICE. I ALSO UNDERSTAND THAT SHASTA PHYSICAL THERAPY WILL CONSIDER REQUESTS FOR RESTRICTION ON A CASE BY CASE BASIS, BUT DOES NOT HAVE TO AGREE TO RESTRICTIONS.

I HEREBY CONSENT TO THE USE AND DISCLOSURE OF MY PERSONAL HEALTH INFORMATION FOR PURPOSES AS NOTED IN SHASTA PHYSICAL THERAPY NOTICE OF INFORMATION PRACTICES. I UNDERSTAND THAT I RETAIN THE RIGHT TO REVOKE THIS CONSENT BY NOTIFYING THE PRACTICE IN WRITING AT ANY TIME. I UNDERSTAND THIS AUTHORIZATION DOES NOT AFFECT MY CONSENT TO USE MY PROTECTED HEALTH INFORMATION FOR TREATMENT, BILLING, OR OPERATIONS RELATED TO TREATMENT AND BILLING.

PATIENT NAME (PRINT) _____

SIGNATURE _____ DATE _____