THRIVE
PHYSICAL THERAPY & WELLNESS

5227 BARTON RD.
WILLIAMSBURG, VA 23185
PHONE: (512) 787-4499
FAX: (512) 957-1215
E-MAIL: REBEKAH@THRIVEPHYSICALTHERAPYWELLNESS.COM
WEB: THRIVEPHYSICALTHERAPYWELLNESS.COM

INFORMED CONSENT

Medical Release for Thrive Physical Therapy & Wellness, PLLC to Release Records: I hereby authorize Thrive Physical Therapy & Wellness, PLLC to release to healthcare providers copies of all medical reports, progress notes, physicians orders, itemized statements, and any other documents relating to any examination or treatment pertaining to the said patient. This release also authorizes verbal communication by Provider to the party who is to receive medical records.

Authorization for Healthcare Provider to *Release Records to Thrive Physical Therapy & Wellness*: I hereby authorize all healthcare providers to release unto Thrive Physical Therapy & Wellness, PLLC all medical reports, progress notes, physicians orders, itemized statements, and any and all other documents relating to any examination or treatment. This release alto authorizes verbal communication by the healthcare Provider to the party who is to receive the medical records.

Use and Disclosure of Your Protected Health Information: Your protected health information will be used by Thrive Physical Therapy & Wellness, PLLC or disclosed to others (e.g. designated representative, spouse, caregiver, etc.) for the purposes of treatment, obtaining pavement, or supporting the day-to-day healthcare operations of the practice.

Notice of Privacy Practices: You are encouraged to review our **Notice of Privacy Practices** for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

_____Initial here indicating you received and reviewed a copy of the privacy practices.
_____Initial here indicating you reviewed the Notice of Privacy Practices and decline a physical copy.

Requesting a Restriction on the Use or Disclosure of Your Information: You may request a restriction on the use or disclosure of your protected health information for the purposes of treatment, payment or healthcare operations.

Thrive Physical Therapy & Wellness, PLLC may or may not agree to restrict the use or disclosure of your protected health information.

If **Thrive Physical Therapy & Wellness, PLLC** agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed-upon restriction will be a violation of the federal privacy standards.

Revocation of Consent: You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices: Thrive Physical Therapy & Wellness, PLLC reserves the right to modify the privacy practices outlined in the notice.

Photography: I hereby understand that photography, videography, and any other form of media maybe used for evaluation, treatment or educational purposes.

_____Initial here if you **do not** consent to photography release.

Media Release: I hereby understand and authorize the use of photography, videography, and any other form of media to be used for promotional and/or educational purposes including, but not limited to: printed publications, website, and/or social media.

_____Initial here if you **do not** consent to media release.

Signature: I have reviewed this consent form and give my permission to **Thrive Physical Therapy & Wellness, PLLC** to use and disclose my health information in accordance with the purposes of treatment, payment and healthcare operations. A photocopy of this authorization form will have the same force and effect of the original thereof. Should I wish to revoke any of this authorization, I will be required to request the revocation in writing.

Printed Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____