

**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. Heuser Physical Therapy, 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 Heuser Physical Therapy is done in an open setting where incidental disclosures may occur. Private consultations are available on request. You also agree that Heuser Physical Therapy 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 Heuser Physical Therapy's NOTICE OF PRIVACY PRACTICES containing a description of your rights, and permitted uses and disclosures, under HIPAA. While Heuser 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 Heuser Physical Therapy at any of its offices or by sending a written request with return address to 3180 Dredge Dr., Suite F, Helena, MT 59602, Attn: Privacy Officer. You have the right to revoke this authorization, in writing, at any time, except to the extent that Heuser Physical Therapy has taken action in reliance on it. A revocation is effective upon receipt by Heuser 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 Heuser 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: \_\_\_\_\_