HIPAA Consent Form

I give *Good Life Physical Therapy* my consent to disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations quality reviews *(Information will only be shared with appropriate physician(s), surgeon(s) or other healthcare professionals pertinent to patient care)*. I have been informed that I may review the clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this clinic has the right to change their privacy practices and that I may obtain any revised notices at the clinic.

I understand that I have the right to request a restriction of how my protected health information is used. If specific restrictions are requested, they must be presented in writing.

I also understand that I may revoke this consent at any time, by making a request in writing, except for the information already used or disclosed.

With this consent, *Good Life Physical Therapy* may call my provided phone numbers and leave a message on voice mail or with any person answering the phone in reference to any items that assist the office in carrying out treatment, and health care operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care.

Signature:_____Date:_____
Patient, parent, or legal guardian

If patient representative, relationship to patient:_____

Good Life Therapy will abide by all HIPAA laws and agreements and will not share patient information with any non-pertinent personnel. However, *Good Life Therapy* has the right to share necessary information in cases of suspected abuse and/or in cooperation with federal or state authorities.

Ryan Gary, PT, Owner of *Good Life Therapy*

Good Life
Physical Therapy
www.goodlifegr.com