WALKER PHYSICAL THERAPY & SPORTS INJURY CENTER

NOTICE OF PRIVACY

PATIENTS PROTECTED HEALTH INFORMATION

This notice describes how health care information, about you, may be used, disclosed and how you can get access to this information. Please review carefully. This office abides by the terms described in this policy.

I. This office uses and discloses your protected health information for the following reasons*:

1. To share with other treating health care providers regarding your health care
2. To submit to insurance companies or workers compensation claims to verify that treatment has been rendered
3. To determine patient's benefits in a health care plan
4. Releasing information required by state or federal public health law
5. To assist in overcoming a language barrier when caring for a patient
6. To provide written assurances to business associates that your privacy has been attained/maintained
7. Emergency situations
8. Abuse, neglect or domestic violence
9. Appointment reminders to household members or answering machines
10. Sign-in logs may be disclosed to verify office visits

II. You have the right to:

1. Revoke authorization, in writing, at any time by specifying what you want restricted, and to whom
2. Speak to our staff regarding privacy issues. Our privacy officer can be reached at the number listed below.
3. Inspect, copy and amend your protected health information and amend it *as allowed by law*
4. Obtain an accounting of disclosures of your protected health information
5. To render a complaint to our privacy officer or the Secretary of Health and Human Services

** Any other uses or disclosures will only be made with your specific, written prior authorization or as indicated below.*

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy, upon request, at any time from the staff at Walker Physical Therapy, Inc.

I hereby authorize information to be released only to the following person(s) listed below:

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

I acknowledge that I have received and reviewed this notice with full understanding as indicated by my own or my legal representative's signature below:

Print Patient's Name _____ Signature of Patient/Legal Representative _____ Date Signed _____

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