ABILITY PHYSICAL THERAPY

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
## Ability Physical Therapy, LLC
## HIPPA

My "protected health information" means health information, including my demographic Information collected from me and created or received by my physician, rehab facility, another health care provider, a health plan, and my employer or a health care clearinghouse. This protected health information relates to my past, present, and/or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Ability Physical Therapy is not required to agree to the restrictions that I may request; however, if Ability Physical Therapy agrees to a restriction that I request then the restriction is binding. I have the right to revoke this consent, in writing, at any time, except to the extent that Ability Physical Therapy has taken action in reliance on this consent.

I understand I have the right to review Ability Physical Therapy's Notice of Privacy Practices, which has been made available to me, prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, and in the performance of health care operations of the Ability Physical Therapy. This Notice of Privacy Practices also describes my rights and Ability Physical Therapy's duties with respect to my protected health information. Ability Physical Therapy reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

____________________________________ ________________________________

Signature of Patient or Personal Representative — Date

____________________________________ ________________________________

Print Name of Patient — Personal Representative's Authority

**I hereby authorize the release of my Protected Health Information to the following individuals (Please Print):**

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this ***Notice of Privacy Practices Acknowledgement***, but was unable to do so as documented below:

| Date: | Initials: | Reason: |
|---|---|---|
| | | |

REVISED 9/1/12