



**PRIVACY CONSENT FOR USE or DISCLOSURE of PATIENT INFORMATION  
FOR THE PURPOSE OF TREATMENT, PAYMENT and HEALTH CARE  
OPERATIONS** **Effective Date: April 14, 2003**

I hereby consent to Physical Therapy Associates, Inc. using or disclosing my protected health Information for the purposes of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health operations. I also consent to the Practice using or disclosing my protected health information for treatment activities provided by my health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

I further acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Name of Patient or Personal Representative (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority

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Practice Use Only: \_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date