USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize Advanced Hand Rehabilitation (AHR,PC) the full use and disclosure of my protected health information (PHI) for the purposes of treatment, payment, and healthcare operations as indicated in the Patient Privacy Notice. My signature acknowledges that I have: (1) received a copy of, and/or been provided the oportunity to review the Patient Privacy Notice, (2) provided complete and accurate information, and (3) provided written consent for medical treatment from AHR,PC, employed and/or contracted therapists.

I authorize the treating therapists and/or designated AHR, PC employees to discuss with and/or release my medical information to:

SPOUSE:_____
LEGAL GUARDIAN OR P.O.A.:_____
OTHER:_____ RELATIONSHIP:_____
SCHOOL/TEAM ATHLETIC TRAINER:_____
SCHOOL/TEAM COACH:_____

I **do not** object to: (please *initial)*
Phone calls to my: _____ home**,**_____ place of employment,_____ spouse
Messages left on: _____ my answering machine,_____ with a person named above

I have been provided a copy of the Patient Privacy Notice prior to signing this acknowledgement, and that I have the right to revoke this authorization at any time. My revocation must be in writing with an explanation.

_____ _____
PATIENT NAME REPRESENTATIVE NAME

Relationship of Personal Representative to the Patient_____

_____ _____
SIGNATURE DATE

AHR, PC reserves the right to change our privacy practices as permitted and required by law. Revised Notices will be posted, and be made available upon request.