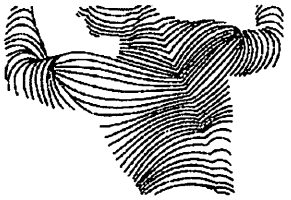

*SPECIALIZED PHYSICAL THERAPY*
*250 El Camino Real, Suite 100*
*Tustin, CA 92780*
*Phone (714) 838-6999 / Fax (714) 838-7099*

CostaMesa Physical Therapy

*COSTA MESA PHYSICAL THERAPY*
*2951 Harbor Blvd*
*Costa Mesa, CA 92626*
*Phone (714)427-0803 / Fax (714) 427-0785*

## HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law. The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. The practice may condition receipt of treatment upon execution of this consent. However, such a revocation will not be retroactive.
- Most email services do not utilize encrypted emails and a third party may be able to access information over the internet.
- Federal government guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email

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Please mark YES or NO to the questions below.

| | | |
|---|---|---|
| May we phone, email, or send a text to you to confirm appointments? | YES | NO |
| May we email medical records to you, appointed person(s), or healthcare provider(s)? | YES | NO |
| May we leave a message on your answering machine at home or on your cell phone? | YES | NO |
| May we discuss your medical condition with any member of your family? | YES | NO |

***If YES**, please name the members allowed:

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____