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HIPAA

CONSENT AND ACKNOWLEDGEMENT FORM

I understand that with my consent, Progressive Therapy Associates may use and share with others my personal health information for purposes of treatment, to obtain payment for treatment services if appropriate, and for health care operations. I understand that if I do not consent, Progressive Therapy Associates will be limited in their ability to serve me. My information may be released to others for certain uses permitted by state and federal law. These possible uses and disclosures are described more fully in the *Notice of Privacy Practices*.

I understand that I have the right to have my personal health information handled in a confidential manner, housed in a secure environment, and accessed only by authorized persons who have a need and right to know the information. I have the right to access and amend my information, request corrections or restrictions, and to receive an accounting of certain disclosures. I have the right to receive confidential communications at an alternate location or in a different way. I have the right to file a complaint with Progressive Therapy Associates and with the U.S. Department of Health and Human Services, Office of Civil Rights.

I consent to the use and disclosure of my health information for purposes of treatment, payment, and health care operations. I acknowledge that I have read the Notice of Privacy Practices that describes how my personal health information may be used or shared with others, my rights with regards to this information, and the legal obligations of Progressive Therapy Associates.

Patient Name: _____

Signature of Patient or Legal Representative

Date

(if not patient, state authority/relationship)

Date