GOUVERNEUR PHYSICAL THERAPY, PLLC

Consent for Disclosure of Protected Health Information

I understand that as part of my treatment, payment for my treatment, and health care operations (TPO), it may be necessary to disclose my Protected Health Information (PHI) to another entity. I consent to such disclosure for these purposes via telephone, dedicated/secure fax or safeguarded e-mail.

You may contact me by phone at home. ____ Yes ____ No

You may contact me by phone/text at mobile. ____ Yes ____ No

You may contact me by phone at work. ____ Yes ____ No

You may leave messages on my answering machine/voice mail ____ Yes ____ No
____ with anyone in my household
____ only with (give names) ___________________________

In addition to the standard (TPO) disclosures listed above, you may also disclose my Private Health/Billing information to the following person/persons in order for them to assist me in my care:
____.

____ (please initial) I have been advised that I may view the Notice of Privacy Practices for Gouverneur Physical Therapy, PLLC

Patient Name: ____

Patient Signature/Representative:_________________________Date:_________

Relationship to patient: ____

For office use only

____ Patient refused to read/sign
____ Patient is unable to sign
____ Patient is unable to read. The staff read the information to the patient.

Staff Signature: ____

If you have any questions about the HIPPA Privacy Rules, please contact Privacy Officer, at (315)535-4899.