

**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM**

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for **Viewpoint Physical Therapy**. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT RECORDS OR RADIOGRAPHS BE SENT TO OTHER ATTENDING PROVIDER OR FACILITY IN THE FUTURE.**

Please ***print*** name of Patient

Signature of Patient / Guardian

Please ***print*** name of Guardian

Relationship of Guardian to Patient

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- Cell Phone Confirmation
- Home Phone Confirmation
- Work Phone Confirmation
- Email Confirmation
- Text Confirmation
- Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** TO BE CONVEYED VIA:

- Cell Phone Confirmation
- Home Phone Confirmation
- Work Phone Confirmation
- Email Confirmation
- Any of the Above**