Use and Disclosure of Protected Health Information

Section I: Patient Acknowledgement

The educational pamphlet entitled "Notice of Privacy Practices" provides information about how Restore Motion, LLC may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Notice of Privacy Practices states that we reserve the right to change terms described. Should this happen we will display the new policy and effective date. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree with your restrictions, but if we do, we are bound by our agreement with you.

By signing below, you acknowledge that you have read our Notice of Privacy Practices.

_____

Patient's Signature Date

_____

Print Full Name

Section II: Authorization for Use of Answering Machine and/or Voicemail

Restore Motion's physical therapists and administrative staff are routinely unable to contact patients directly during normal business hours. On these occasions, our office leaves messages on communication devices provided by our patients. Due to the new federally mandated HIPAA Privacy Rule, we must obtain your authorization to continue this mode of communication.

___ (Initial) Yes, I agree to allow Restore Motion, LLC's therapists and administrative staff to leave messages, including texts that include Protected Healthcare Information on the following communication devices ***(initial next to those that apply)***

____ Home number ____ Work number ____ Cell number ____ Email ____ Text

___(Initial) Yes, I give my permission to use my E-Mail address to be informed of Restore Motion with scheduling/invoices/news/events. (E-Mail address will not be shared to third parties.)

___ (Initial) No, I do not agree to allow Restore Motion, LLC's therapists and administrative staff to leave messages that include Protected Healthcare Information on my home, work and cell phones.

_____ _____

Patient's Signature Date