



Patient Information Acknowledgement Form

I have read and fully understand LaFayette Physical Therapy's Notice of Information Practices. I understand that LaFayette Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that LaFayette Physical Therapy will consider requests for restrictions on a case by case basis, but does not have to agree to requests for restrictions.

I hereby acknowledge the use and disclosure of my personal health information purposes as noted in LaFayette Physical Therapy's Notice of Information Practices. I understand that I retain the right to revoke this acknowledgement by notifying the practice in writing at any time.

I HEREBY ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE CONTENTS OF THIS RELEASE AND AGREE TO THE TERMS HEREIN.

Date: _____

Patient Signature or Authorized Party

Print Name: _____

Indicate Relation ship if signing for patient

Patient Name _____ Date Of Birth _____

Patient Address _____

Emergency Contact Name _____

Emergency Contact Phone Number _____