Acknowledgement of receipt of notice of Privacy Practices HIPAA

By signing below, I acknowledge that I have been offered or provided a copy of Integrated Physical Therapy of Colorado Notice of Privacy Practices.

Consent to Treat

I authorize Integrated Physical Therapy of Colorado to render services as deemed necessary for the care of the above named Patient.

HIPAA Medical Information Release

Release of Information:

[ ] I authorize the release of information from Integrated Physical Therapy of Colorado, including the diagnosis, records, examination rendered to me and claims/billing information. This information may be released to:

[ ] Spouse_____
[ ] Child(ren)_____
[ ] Other_____
[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages:

Please call: [ ] my home [ ] my work [ ] my cell number ____

If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] do not leave a message
[ ] (other)_____

The best time to reach me is (*day*)_____ between (*time*)_____

Your signature below indicates:

1. You read and understand the Acknowledgement of receipt of Notice of Privacy Practices
2. You understand and agree to the Consent to Treat
3. You read and understand the Medical Information Release.

Patient Signature:	Date:
Patient Name:	Date of Birth: