PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

We may use and disclose your medical information for purposes of treatment, payment and health care operations.
We may use or disclose your medical information without your written authorization as required by law.
The following are examples in which this may be necessary:

- To report death, disease or injury, as part of a public health investigation, or to report child abuse or domestic violence.
- In response to a subpoena or other legal process or that of another person.
- Specialized government functions, national security, intelligence activities, or for correctional activities.
- Workers Compensation programs as established by law.
- To a person who has the authority, under law, to act on your behalf.
- Your statements, comments, and photo may be used on correspondence, promotional materials, newsletters, websites, etc.

We may use or disclose your medical information in ways described below after giving you an opportunity to object:

- To a family member or friend who is involved in your medical care.
- To an entity assisting in disaster relief in order for your family to be notified of your condition.

DISCLOSURE AUTHORIZATION: I give my permission to release medical and financial information to:

Name: _____ **Relation:** _____ **Name:** _____ **Relation:** _____

Name: _____ **Relation:** _____ **Name:** _____ **Relation:** _____

We may use or disclose your medical information for other purposes once we have obtained your written authorization.
Your rights regarding medical information about you are listed below.
For documentation purposes, requests and/or restrictions require using a form that we will provide you.

- Right to request restrictions on disclosure
- Right to receive confidential communications
- Right to inspect and copy
- Right to amend
- Right to an accounting of limited disclosures
- Right to a paper copy of this notice in detail
- We reserve the right to make changes as HIPAA guidelines may require.

If you have any questions or concerns, please feel free to contact our Compliance Officer.

SIGN BELOW TO ACKNOWLEDGE THAT YOU HAVE RECEIVED A COPY OF OUR NOTICE OF PRIVACY PRACTICES.

Signature of patient or patient's representative: _____ Date: _____

Print name of patient or patient's representative: _____ Relation: _____

Please return this acknowledgement as soon as possible. If you received this form when you arrived at our practice of service, return this form in person before you leave. If you do not return the form in person, you may return this form by mail to our privacy officer at the following address:

Teays Physical Therapy Center, Inc.
3910 Teays Valley Road
Hurricane, WV 25526
Attn: Compliance Officer

FOR USE ONLY BY REPRESENTATIVE OF TPTC

A good faith effort was made to obtain a written acknowledgement of receipt of our Notice of Privacy Practices that was provided to (circle one) the patient/the patient's representative on _____/_____/_____.

The acknowledgement was not obtained for the following reason(s): _____

_____

Signature of Representative: _____

Revised: 05-09-11