PROTECTED HEALTH INFORMATION
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PATIENT INFO

First Name _____ Last Name:_____

This notice describes how care information about you may be used and disclosed and how you can get access to this information. Please review it carefully. TheraPhysical office abides by the terms described in this policy.

TheraPhysical office discloses your protected health care information for the following reasons.

1. To share with other treating health care providers regarding your health care
2. To submit to insurance companies or Workers' s comp claim to be verify that treatment has been rendered
3. To determine patient's benefits in a health care plan
4. Releasing information required by State or Federal Public Health Law
5. To assist in overcoming a language matter when caring for a patient
6. Business associated providing written assurances for your privacy have been attained
7. Emergency situations
8. Abuse, neglect or domestic violence
9. Appointment reminders to household members or answering machines
10. Sin-In logs may be disclosed to variety office visits

Any other uses or disclosures will only be made with your specific written prior authorization

You have the right to:

1. Revoke authorization, in writing at any time by specifying what you want to restrict and to whom
2. Speak to our privacy officer ___Ewelina _____regarding privacy issues, and can be reach out at 201 340 4656
3. Inspect, copy and amend your protected health information and amend it as allows by law
4. Obtain an accounting of disclosures of your protected health information
5. To render a complain to our privacy officer or the Secretary of health and Human Services

TheraPhysical office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and reviewed this notice with full understanding.

Patient Signature _____ Date _____