## Theresa A. Schmidt, MS,PT,PC DBA: Flex Physical Therapy

**P.O. Box 643, Northport NY 11768 877-281-3382**

NOTICE OF PATIENT INFORMATION PRACTICES

HIPAA: Patient Acknowledgement of Receipt Of Privacy Practices Notice

This is to acknowledge that I have received and reviewed Theresa A. Schmidt, MS,PT,PC, DBA: Flex Physical Therapy’s Notice of Privacy Practices. If I have any questions, I can contact the Practice at: 877-281-3382.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Signature of Patient

# Patient Authorization Form

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(*PRINT NAME OF PATIENT),* authorize , Theresa A. Schmidt, MS,PT,PC, DBA: Flex Physical Therapy to: (check those that apply)

\_\_\_\_ Use the following protected health information and/or

\_\_\_\_ Disclose the following protected health information

to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*INSERT NAME OF INDIVIDUAL OR ENTITY TO RECEIVE THE INFORMATION*

Description of information to be disclosed: (dates and type of service provided, origin of information, level of detail to be released)

 \_\_\_\_\_Medical records to my physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The purpose for this use/disclosure is:

This authorization is effective until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. After this date or event, this authorization expires. I understand that after the person or entity receives the information authorized by this disclosure it may no longer be protected by federal or state law and may be disclosed by the receiving party. I understand that I have the right to revoke this authorization by sending written notification to Theresa A. Schmidt at: Theresa A. Schmidt, MS,PT,PC, DBA: Flex Physical Therapy P.O. Box 643 Northport NY 11768. I understand that Theresa A. Schmidt, MS,PT,PC, DBA: Flex Physical Therapy will not use the signing of this authorization as a condition for treatment or billing. I understand that I have the right to:

* Inspect or copy the protected health information to be used or disclosed as permitted under federal or state law (Whichever is most liberal) and/or
* Refuse to sign this authorization

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Personal Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Patient or Personal Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Personal Representative’s Authority