Physical Therapy and Hand Center, L.L.C.

Consent to Use and Disclose Health Information

Patient Name:____
Last First MI

Date Of Birth ________/________/________

CONSENT REGARDING GENERAL INFORMATION

By my signature below, I hereby consent to the use or disclosure of my health information in order that ProCare Physical Therapy & Hand Center, L.L.C. may carry out treatment, payment, or health care operations. For purposes of this consent, health information shall mean all information relating to health care services provided to me by ProCare, including, without limitation, information relating to services provided to me prior to this date.

The practice has provided me its Notice of Privacy Practice ("the Notice") that explains, among other things, the definitions of treatment, payment and health care operations and the types of uses or disclosures that ProCare can make if I signed this consent. I have had an opportunity to review the Notice before I sign this consent. I further understand that ProCare may change the terms of the Notice from time to time, and that I may contact the Practice's Office Manager, at the address listed below, to obtain a revised version of the Notice at any time.

I understand that I may at any time submit in writing to the Office Manager, at the address listed below, at ProCare to restrict how my health information is used or disclosed to carry out treatment, payment, or health care operations. ProCare is not required to agree to my requested restriction. In the event ProCare does agree to the requested restriction, however, the restriction will be binding.

I understand that this consent will remain in effect until I provide a written notice of revocation to the Office Manager at the address listed below. The revocation will be effective immediately upon ProCare's receipt of my written notice, except that the revocation won't have any effect on any actions ProCare took before it received my written notice.

The address of the Office Manager is as follows:

1900 Lafayette Rd
Suite C
Portsmouth, NH 03801
Phone: (603) 431-5600

I understand that if I refuse to sign this consent or if I revoke this consent in the future, ProCare will not provide any treatment to me or arrange for treatment on my behalf, may not bill for the services provided, and may discharge me as a patient, to the extent permitted by law.

______________________________ ____________
Signature of Patient / Guardian **Date**

____
Printed Name of Patient / Guardian

Owned by Sports Medicine Atlantic Orthopaedics