

Consent Form

By signing this form, I hereby give consent to **Pro•Motion Physical Therapy** to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how **Pro•Motion Physical Therapy** may use and disclose my confidential information.

I understand that **Pro•Motion Physical Therapy** has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available by calling the main office at (815) 521-4400 by requesting that a revised copy be sent to me in the mail or asking for one at the time of my next appointment.

I have the right to revoke this consent in writing, except to the extent **Pro•Motion Physical Therapy** has already used or disclosed my protected health information in reliance on my consent.

X _____
Patient Signature/Legal Guardian Date

X _____
Print Patient Name/Legal Guardian

Refusal to Sign

Patient name: _____

Employee name: _____

Revocations

I hereby revoke the consent given above.

X _____
Patient Signature/Legal Guardian Date

X _____
Print Patient Name/Legal Guardian

If you are signing as patient's representative.

Name (print): _____

Describe your authority: _____

815.521.4400

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