



PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand Rapha Physical Therapy, Inc's Notice of Privacy for Protected Health Information. I understand that Rapha Physical Therapy, Inc. may use or disclose my personal health information for the purposes for carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Rapha Physical Therapy, Inc. will consider requests for restriction on a case-by-case basis, but doesn't have to agree to requests for restrictions.

I hereby acknowledge the use and disclosure of my personal health information for purposes as noted in Progressive Physical Therapy, Inc.'s Notice of Policy for Protected Health Information. I understand that I have the right to revoke this consent by notifying the practice in writing at any time.

Patient Name

Signature

Date