**NOTICE OF PRIVACY PRACTICES:**

We are committed to protecting health information about you. All information that identifies you will be kept private, and disclosed only when you authorize disclosure, except when disclosure is required to provide treatment, coordinate your care with other treating providers, perform health

care operations of this facility, or receive payment for your care. You may be treated in a common area for physical therapy. If you object to this please let your therapist know and we will accommodate your request to the fullest extent possible.

You have the right to inspect and copy health information that may be used to make decisions about your care. A request must be submitted in writing on the form we have available. We may charge a fee for copies of any records requested.

You have the right to amend health information if you feel entries are incorrect or incomplete. A request must be made in writing on the form we have available. You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described. A

request must be made in writing on the form we have available. You have the right to request restrictions on disclosures, request confidential communications in the way that we contact you, and file a complaint, submit the complaint in writing on the form we have available to Julie Knoll,

Privacy Official. You will not be penalized in any way for filing a complaint, or making any of the requests listed above. A copy of the entire Notice of Privacy Practices, which contains more detail regarding the above information, is available.

**I have been provided with the information regarding privacy practices, understand the practices, and understand that I may make a verbal request to receive a detailed copy of the Privacy Notice at any time.**

**Sign Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I authorize Physical Therapists of South Valley Physical Therapy, PC**

**to provide me with physical therapy evaluation and treatment.**

**Sign Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**