PHYSICAL THERAPY SOLUTIONS, LLC

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Physical Therapy Solutions' Notice of Patient Information Practices. I understand that Physical Therapy Solutions may use or disclose my personal health information for the purposes or 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 Company in writing. I also understand that Physical Therapy Solutions will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Physical Therapy Solutions' Notice of Patient Information Practices. I understand that I retain the right to revoke this consent by notifying the Company in writing at any time.

Patient Name (print): ___________________________________ Date: __________________________

Signature: ____

DESIGNATED INDIVIDUALS AUTHORIZATION

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: ____ Relationship: ___________________

Name: ____ Relationship: ___________________

Signature: ____ Date: __________________________