PHYSICAL THERAPY CENTER OF ROCKY HILL

CONSENT FORM FOR USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, the undersigned patient, consent to have PHYSICAL THERAPY CENTER OF ROCKY HILL ("PTC") use and disclose my protected health information (PHI), including, if applicable, drug/alcohol abuse, HIV and psychiatric information for the purposes of my treatment, healthcare operations and payment by the payer (s) of my health care benefit.

In addition, I consent for PHYSICAL THERAPY CENTER OF ROCKY HILL to disclose my protected health information to the following for the following:

- ***Primary Care or referring Physician for follow-up care;***
- ***To other providers for referral and discharge planning;***
- ***To other providers for coordination of care***

I have been provided with PTC's Notice of Privacy Practices and understand that I have the right to review this notice before signing this consent. I understand that PTC reserves the right to change its privacy practices, described in its Notice, and that if I wish to receive notification of any changes to the notice, I may contact PTC at: (860) 513-1431 or via email: PhysicalTherapyCenter@gmail.com

I understand that I have the right to refuse signing this consent. If I refuse to sign this consent, PTC may provide me with treatment however; I will be responsible for charges incurred at time of service. I understand that treatment required by law, such as emergency care will be provided to me whether or not I sign this consent.

Unless I object, PHYSICAL THERAPY CENTER OF ROCKY HILL may disclose protected health information of a general nature to my family or other individuals personally involved in my care, including changes in my condition.

I have the right to request that PTC restrict how they use and/or disclose my protected health information for the purpose of providing treatment, obtaining payment and/or conducting health care operations. PTC is not required to agree to any restriction I request. If PTC does decide to agree to my request, PTC must honor the restriction placed on the use and/or disclosure of my health information. I also understand that I have the right to request confidential communications by PTC means or locations. However, PTC may deny the request if it determines that it would be administratively difficult to comply with my request.

I understand that with respect to drug/alcohol abuse, HIV and psychiatric information, this Consent will expire 365 days after the date appearing below or 365 days after my final treatment, whichever is later. I also understand that I have the right to revoke this consent by notifying PTC at the clinic where I receive care in writing. I understand that if I revoke my consent, there will be no effect on uses and disclosures already made in reliance on my prior consent.

I have had the opportunity to have my questions answered regarding PTC privacy practices. I have read a copy of the Notice of Privacy Practice and consent to the use and disclosure of my protected health information for treatment, payment and healthcare operations.

X _____ ***X*** _____

Signature of Patient or Legal Representative/Witness ***Date***

If signed by the Legal Representative, indicate your relationship to the patient below:
☐ Parent ☐ Guardian ☐ Conservator ☐ Executor of Estate ☐ Power of Attorney ☐ Other_____

If unable to obtain patient's consent, indicate the reason below:

☐ Emergency treatment situation
☐ Required by law to treat the patient and PHYSICAL THERAPY CENTER OF ROCKY HILL has attempted but is unable to obtain the patient's consent.
☐ Substantial barriers to communicating with the patient (ie. Foreign language) and PHYSICAL THERAPY CENTER OF ROCKY HILL determines that the patient's consent to receive treatment is inferred from the circumstances.
☐ Patient refuses to sign the consent

_____ _____

Signature of Witness (Person documenting reason) ***Date***

NOTICE

HIV RELATED INFORMATION
In the event that information released constitutes confidential HIV related information protected under Connecticut Law:
This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.
PSYCHIATRIC INFORMATION
If the event that information released constitutes confidential psychiatric information protected under Connecticut Law:
This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it or of using it for any purpose other than that indicated above without the specific written consent by the person to whom it pertains, or as otherwise permitted by said law.
DRUG AND ALCOHOL ABUSE RECORDS
In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records Regulations: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.