Acknowledgement AND Consent of Health Information

I understand that **Northwest Rehabilitation Associates,** (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information. I may be used for photographed or videotaped to document my medical treatment or condition and that this may be used for educational purposes.

I understand and agree that This Practice may use and disclose my health information in order to:
• Make decisions about and plan for my care and treatment;
• Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
• Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
• Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

Permission to release confidential medical information to family members, friends or legal representatives

Print Name: _____ Date of Birth _____

I authorize NWRA to release information to: (Please mark all that apply).

Spouse/Significant Other's Name: _____ Phone # _____

☐ Discuss information regarding my appointment ☐ Discuss my medical condition ☐ **All**
☐ Leave phone messages ☐ Emergency Contact ONLY

Name: _____Relationship _____Phone # _____

☐ Discuss information regarding my appointment ☐ Discuss my medical condition ☐ **All**
☐ Leave phone messages ☐ Emergency Contact ONLY

Additional: _____

I understand that I may revoke or change this authorization at any time. You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to NWRA. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation.

☐ **I do not want information shared with anyone other than myself.** Subject to HIPAA regulations. See above.

By signing below, I agree that I have reviewed the information above and that I have been offered a copy of the Notice of Privacy Practices.

Print Name: _____Patient Signature _____Date_____

_____ Date _____

(If unable to sign, patient's Authorized Representative) (Relationship)