HIPAA NOTIFICATION

REHAB PARTNERS, INC. IS REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF YOUR PERSONAL HEALTH INFORMATION AND TO PROVIDE YOU NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES AND ADHERE TO THIS NOTICE. WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE NEW PROVISIONS EFFECTIVE FOR ALL INDIVIDUALLY INDENTIFIABLE HEALTH INFORMATION THAT WE MAINTAIN. IF WE DO CHANGE OUT INFORMATION PRACTICES, WE WILL POST A NOTICE THAT THE NOTICE HAS CHANGED AND THE EFFECTIVE DATEOF THE CHANGE. COPIES WILL BE MADE AVAILABLE UPON REQUEST.

I UNDERSTAND THAT REHAB PARTNERS, INC. HAD MADE AVAILABLE TO ME A COPY OF THE NOTICE OF PRIVACTY PRACTICES. BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES.

PATIENT SIGNATURE: _____

DATE: _____

Because of the nature of this practice, it may be necessary to contact you by telephone for examination results, scheduling, appointments, billing, etc. HIPAA requires that we obtain specific consent from our patients allowing us to speak with others on your behalf should you not be available. Please indicate below the names, relationships, and date of birth of those you will allow us to speak with on your behalf. This would include your SPOUSE, FAMILY MEMBERS, CARE GIVERS, ETC.

NAME: _____

RELATIONSHIP: _____

DATE OF BIRTH: _____

NAME: _____

RELATIONSHIP: _____

DATE OF BIRTH: _____

NAME: _____

RELATIONSHIP: _____

DATE OF BIRTH: _____

If you **DO NOT** want us to speak with anyone with regards to your treatment, appointments, billing, etc. please indicate so by signing below.

NAME: _____

DATE: _____