O'NEILL PHYSICAL THERAPY
227 N. CLEVELAND AVE· HAGERSTOWN, MD 21740
301-733-3844·301-733-3804 FAX
physicaltherapy@myactv.net

HIPAA Form

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment and for health care operations.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices for a complete description of uses and disclosures before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they my follow the restrictions.

I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or dislosed.

Signature: _____ Date: _____

If signed by patient representative, state relationship to patient: _____