



Form

5.01.13.07 Patient Privacy Notice

Protected Health Information (PHI) Any health information or patient information used or disclosed by a covered entity in any form, including oral, recorded, on paper, or electronic.

This is personal health information that includes or contains information that connects the patient to the information. Examples include an individual's name and address, social security number, or other identification number, medical health provider's personal notes and billing information.

RELEASE-Stanwood Camano Physical Therapy, PLLC is permitted to use or disclose PHI for treatment, payment, and healthcare operations, with authorization or agreement from the individual patient, for disclosure to the individual patient, and when required by the Department of Health and Human Services for compliance or investigation. As a patient, you authorize mutual exchange of information between Stanwood Camano Physical Therapy, PLLC (SCPT), referring healthcare providers, and insurance carriers concerning your injury/condition and treatments. We will require a signed authorization from the patient to use or disclose PHI for purposes other than these.

AUTHORIZATION-Information will only be released with a fully executed Medical Record Authorization, signed and dated by the patient, except as allowed by law.

PATIENT RIGHTS-Patients have the following rights:

- The right to receive a Privacy Notice at the time of first delivery of service
- The right to restrict use and disclosure, although the covered entity is not required to agree.
- The right to have PHI communicated to them by alternate means and at alternate locations to protect confidentiality.
- The right to inspect, correct, and amend PHI and obtain copies, with some exceptions.
- The right to request a history of non-routine disclosures for six years prior to the request.
- The right to contact designated persons regarding any privacy concern or breach of privacy within the facility.
- **RECEIPT OF NOTICE**-Patients will receive notice of his or her rights on the first date of service delivery. Patients will be requested to sign a receipt of notice, and have a written copy available to them. Such receipt of notice, or documentation of reasons why it was not obtained, will be kept in the patient's chart.

CONTACT-Patients may contact the Clinic Manager regarding any privacy concerns they may have within this facility.

ADDITIONAL RELEASE:

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- ☐ Spouse _____
- ☐ Child(ren) _____
- ☐ Other _____

By signing this I am stating that I have read and received a copy of the Patient Privacy Notice.

Patient (or Guardian if under 18) Signature

Date Signed

Print Name