419 South Pasadena Avenue
St. Petersburg, FL 33707
Phone: 727-384-4600
Fax: 727-384-4601

CONSENT TO TREAT/ PRIVACY PRACTICES

I consent to the use or disclosure of my protected health information by **FYZICAL THERAPY & BALANCE CENTER** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. Therefore I authorize, by my signature on this document, for **FYZICAL THERAPY & BALANCE CENTER** to evaluate and treat my condition. I understand that diagnosis or treatment of me by **FYZICAL THERAPY & BALANCE CENTER** and/or its employees may be conditioned upon my consent.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. **FYZICAL THERAPY & BALANCE CENTER** is not required to agree to the restrictions that I might request. However if **FYZICAL THERAPY & BALANCE CENTER** agrees to a restriction that I request, the restriction is binding on **FYZICAL THERAPY & BALANCE CENTER and any employee of that entity.**

My protected health information means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical, mental health condition, and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to allow the release of PHI to the following persons/ Medical Professionals:

Referring Physician _____ PCP _____ Family Member _____

I have the right to revoke this consent, in writing, at any time, except to the extent that **FYZICAL, Inc.** has taken action in reliance to this consent.

I understand I have the right to review **FYZICAL THERAPY & BALANCE CENTER'S** Notice of privacy practices prior to signing this document. The notice of privacy practices will be (*upon Request*) provided to me. The notice of privacy practices is also located in the waiting area of FYZICAL THERAPY & BALANCE CENTER in a 3 ring binder notebook.

FYZICAL, Inc. reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices** at any time, where notice will be placed in the manner of a posted notice.

I may obtain a revised notice by calling the intake coordinator at (727) 384-4600 and requesting a revised copy.

_____ _____

Signature of patient or personal representative *Date*

_____

Print name of Patient or personal representative

_____ _____

FYZICAL Therapy & Balance Center, Inc *Date*
Authorized Representative