CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I _____ have had full opportunity to read the Capitol Physical Therapy LLC's Notice of Privacy Practices. I understand that by signing this consent, I am giving my consent to Capitol Physical Therapy LLC to use and disclose my protected health information to carry out treatment, payment activities and health care operations. I understand the terms of this notice may change with time and Capitol Physical Therapy LLC will always post the current notice at the clinic or on the website and have copies available for distribution.

Indicated below are individuals whom Capitol Physical Therapy LLC may speak to regarding my treatment. Please list names.

_____

_____

_____

Listed below are individual(s) whom I request restriction regarding my protected health information.
Not Applicable

_____

_____

_____

We may need to contact you. Do we have your permission to leave a confidential message at the phone numbers you have provided us? (Please circle one)

Yes **No**

_____

(Sign and Date)