Genesee Valley Physical Therapy

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, hereby acknowledge that at anytime, I may request a copy of the Notice of Privacy Practices for **Genesee Valley Physical Therapy & Sports Rehab., P.C..**

_____ _____
Date Signature of Patient or Patient's Representative

_____
Description of Representative's Authority

HIPAA AUTHORIZATION TO OBTAIN AND/OR DISCLOSE TO/FROM OTHER HEALTH CARE PROVIDERS

I, _____, hereby authorize GVPT to obtain or disclose to any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility or other health care provider that has provided payment, treatment or services to me or on my behalf to Genesee Valley Physical Therapy & Sports Rehab, P.C.

_____ _____
Date Signature of Patient or Patient's Representative

HIPAA PRIVACY RULES DESIGNATION OF PERSONAL REPRESENTATIVE

I, _____, designate _____ as my personal representative for purposes of all rights, obligations and responsibilities created under the HIPAA Privacy Rules.

I acknowledge and agree that Genesee Valley Physical Therapy & Sports Rehab., P.C., (the "Practice") may disclose my protected health information to my personal representative and that my personal representative has the authority to authorize the Practice to use and disclose my protected health information.

_____ _____
Date Signature of Patient or Patient's Representative

Are you interested in receiving appointment reminders? **Voice Call___ Text ___ E-mail ___**