Vibrance Physical Therapy and Wellness

Helén Åkerberg Evans, PT
VibrancePTandWellness.com

3295 Triangle Dr SE, Suite 140
Salem, OR 97302

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

AND

CONSENT TO RELEASE OF HEALTH INFORMATION

By law, we are required to provide you with our Notice of Privacy Practices. This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

Acknowledgement of receipt of Notice of Privacy Practices

I understand that Vibrance Physical Therapy and Wellness will use and disclose health information about me. I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that Vibrance Physical Therapy and Wellness may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I understand that the Notice of Privacy Practices describes the uses and disclosures of health information made and the information practices followed by Vibrance Physical Therapy and Wellness, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted on our website and in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that Vibrance Physical Therapy and Wellness is not required to agree to such requests.

By signing below, I acknowledge that I have received and had the opportunity to review the Notice of Privacy Practices on the date below on the behalf of Vibrance Physical Therapy and Wellness.

Printed Name of Patient: _____ Date: _____

Patient Signature or that of Responsible Party: _____

Indicate relationship if Responsible Party (if applicable): _____ Phone: _____

Consent to Notification

In order to ensure that patients receive time-sensitive information and other informational healthcare messages, we, as the provider of rehabilitation therapy send notifications to patients that opt-in to receive such notifications. It is important to note that certain communications, including, without limitation phone and email, which may contain your health information, are not invariably secure since certain communications can be intercepted, delivered and/or addressed to an unintended recipient, and/or improperly accessed while in storage and/or during transmission.

In compliance with the Health Insurance Portability and Accountability Act (HIPAA), we are required by law to maintain the privacy and security of your health information. In addition, pursuant to the HIPAA Privacy Rule and our Notice of Privacy Practices, we will not use and/or disclose your health information without your explicit written authorization, except as permitted by law for the purposes of payment, treatment and health care operations. Furthermore, when we are authorized and/or permitted to use and/or disclose your health information, we will limit the use and/or disclosure of your health information to the minimum amount necessary to accomplish the intended purpose of the use and/or disclosure of your health information.

I hereby consent to receive notification from Vibrance Physical Therapy and Wellness, which may include my health information, by the following modes of communication that I indicate below, with a full understanding of the risks involved with such notifications. I agree to assume all responsibility for informing Vibrance Physical Therapy and Wellness of changes to any of the methods of communications that I indicate below.

I further agree that Vibrance Physical Therapy and Wellness shall not be held liable for ay unauthorized disclosures of my health information to a third party through any of the methods of communication I authorize below.

□ Mobile Device: _____ □ Home Phone: _____
□ Email: _____

Printed Name of Patient: _____ Date of Birth: _____

Patient Signature or that of Responsible Party: _____

Indicate relationship if Responsible Party (if applicable): _____ Phone: _____

Authorization to release your health information to family members, friends, or legal representatives

I authorize Vibrance Physical Therapy and Wellness to release information to: (Please mark all that apply).

Name of Spouse/Significant Other: _____ Phone: _____
☐ Discuss information regarding my appointment ☐ Discuss my medical condition ☐ All
☐ Leave phone messages ☐ Emergency Contact ONLY

Name: _____ Relationship: _____ Phone: _____
☐ Discuss information regarding my appointment ☐ Discuss my medical condition ☐ All
☐ Leave phone messages ☐ Emergency Contact ONLY

I understand that I may revoke or change this authorization at any time by providing Vibrance Physical Therapy and Wellness with written notice of revocation.

☐ I do not want information shared with anyone other than myself. Subject to HIPAA regulations.

By signing below, I agree to the information above.

Patient Signature or that of Responsible Party: _____

Indicate relationship if Responsible Party (if applicable): _____ Phone: _____