PREHAB SPORTS MEDICINE
Physical Therapy
2871 Post Road, Warwick, RI. 02886
Tel: (401) 463-3060 Fax: (401) 732-1045

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALH INFORMATION (PHI)

OUR PRIVACY PLEDGE

THIS NOTICE DESCRIBES HOW YOUR PRIVATE HEALTH CARE INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO IT.

We are very concerned with protecting your privacy. While the law requires us to provide you with this disclosure, please understand that we have and always will respect the privacy and confidentiality of your personal health care information (PHI). We will not sell or provide your PHI to any outside marketing organization.

Under federal law there are circumstances in which we are required to use or disclose your PHI without consent or authorization these include :

- while providing health care services to you based on the orders of another health care provider.
- while providing care in the event of an emergency.

Any other use or disclosure of your health information will only be made with your written authorization.

There are several other instances in which we may need to use or disclose your PHI these include:

- providing your PHI to another health care provider or hospital if it is necessary to refer you for diagnosis, assessment or treatment of your health condition.
- providing your PHI and billing records to another party if they are responsible for payment of your service.
- We may need to use your PHI within our practice for quality control or other operational purposes.

YOUR RIGHTS TO LIMITED USE OF DISCLOSURES

You have the right to request that we do not disclose your PHI to specific individuals, companies and or organizations. If you would like to place any restrictions on the disclosure of your PHI, please let us know in writing. We are not required to agree to these restrictions, however, if we agree the restriction is biding on us.

YOUR RIGHTS TO RESTRICT OR REVOKE YOUR AUTHORIZATIONS

You may restrict the individuals or organizations to which your PHI is released or you may revoke your authorization allowing us to disclose your PHI at any time. Such requests **must be in writing** and mailed to our office at **2871 Post Road, Warwick, RI. 02886**.

If you refuse to grant authorization to disclose your PHI, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for providing your care. We will not be able to honor requests if we have

YOUR RIGHTS TO RESTRICT OR REVOKE YOUR AUTHORIZATIONS (Cont.)

already released your PHI before receiving notice. If you were requested to provide authorization as a condition of obtaining insurance reimbursement, the insurance company may have the right to your PHI if they decide to contest any of your claims.

You may inspect or copy the information we use to contact you regarding appointment reminders, information about treatment alternatives or other PHI related information at any time (§ 164.524).

A more complete and detailed description of how your PHI may be used or disclosed is available upon request. You have the right to review that notice before signing this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for your treatment or by standard mail. Please feel free to contact us call us at any time for a copy of our privacy notices.

APPOINTMENT REMINDERS AND PHI DISCLOSURE AUTHORIZATION

Your Physical Therapist and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health care related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or voice mail. **By signing the authorization you are giving us authorization to contact you by phone with these reminders and other relevant information**.

RE-DISCLOSURE

Information that we use or disclose based on the authorization you provide may be subject to re-disclosure by the person(s) and or organizations with access to the remainder or other information and this information may no longer be protected by federal privacy rules.

This notice is effective as of today's date (see below).
This authorization will expire seven (7) years from date on which you last received services from us.

I, the undersigned, have been given a copy of the notice of privacy for protected health information for Prehab Sports Medicine.	
Patient Name (Please Print)	Patient Signature
Authorized Provider Representative	Date