Patient Rights and Privacy Notice

I have received read and understood the notice of privacy practices which has provided a complete description of the uses and disclosures of my health information as outlined by the Health Insurance Portability and Accountability Act of 1996. I understand that I have certain rights regarding my protected health information and that this information can and will be used for purposes of treatment, payment and normal healthcare operations.

Discussion of Treatment/Medical Information

A. If you are accompanied to your physical therapy session(s) is it acceptable to discuss your medical information with the individual(s) present? Yes_____ No_____

B. Is there any individual, besides your doctor and involved health care practitioner(s), with whom Hubbard Physical Therapy has permission to discuss your treatment plan/medical information? Please check as appropriate and print the individual's name:

Spouse/Significant Other	Y____	N____	_____
Son/Daughter	Y____	N____	_____
Son-in-law/Daughter-in-law	Y____	N____	_____
Friend	Y____	N____	_____
Other	Y____	N____	_____

By signing below, you confirm that you have received a copy of Hubbard Physical Therapy's Privacy Notice and Patient Rights either in person, via email or USP.

Signature of Patient or Responsible Party: _____ Date_____