

# Advanced Health Systems

## Physical Therapy & Wellness

I hereby authorize one or all of the **designated parties** below to request and receive the release of any **Protected Health Information** regarding my treatment, appointments, and payment. This includes any administrative operations related to treatment, appointments, and payment. I understand that the identity of designated parties must be verified before the release of any information.

### Authorized designated person:

Name: \_\_\_\_\_ Phone Number : \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number : \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number : \_\_\_\_\_ Relationship: \_\_\_\_\_

I give permission to leave messages on voice mail or to a person answering the phone regarding my scheduled or missed appointments. In addition, financial statements may be e-mailed to me.

Home: *yes*\_\_\_ *no*\_\_\_      Office: *yes*\_\_\_ *no*\_\_\_      Cell: *yes*\_\_\_ *no*\_\_\_

Email address: \_\_\_\_\_

**Patient Information Acknowledgement:** I have reviewed Advanced Health System's Notice of Information Practices. I understand that Advanced Health Systems may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Advanced Health Systems will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Advanced Health System's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

\_\_\_\_\_  
Patient/Authorized Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name