
# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Your confidential healthcare information may be released to:

- **Other healthcare professionals or other treating physicians for the purpose of providing you with quality healthcare;**
- **Your insurance carrier and/or treating vendor for the purpose of the practice receiving payment for providing you with needed healthcare services;**
- **Public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence;**
- **Other healthcare providers in the event you need emergency care;**
- **A public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication);**
- **Certain parties only after receiving written authorization from you.**

You may revoke your permission to release confidential healthcare information at any time. You may be contacted by Re-Form Physical Therapy & Pilates, LLC to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you. If you are not home and/or unavailable, we may leave appointment information on your answering machine or in a message left with the person answering the phone. We may use and disclose limited protected health information about you by having you sign in when you arrive at our office. We may also call your name when we are ready to see you. You have the right to restrict the use of your confidential healthcare information. However, Re-Form Physical Therapy & Pilates, LLC may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation. You have the right to receive confidential communication about your health status. You have the right to review any/all portions of your healthcare information upon written request within the timeframes set by law. You have the right to request change be made to your healthcare information. You have the right to know if certain parties have accessed your confidential healthcare information and for what purpose. You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper. Your confidential healthcare information may not be released for any other purpose that which is identified in this notice. Re-Form Physical Therapy and Pilates, LLC is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information and will provide patients, upon request, with a list of duties or practices that protect confidential healthcare information. Re-Form Physical Therapy & Pilates, LLC will abide by the terms of this notice. The practice reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information. Any changes to this notice will be posted in our practice within 30 days of making any changes. You have the right to file a complaint to Re-Form Physical Therapy & Pilates if you believe your rights to privacy have been violated.


## Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices for Re-Form Physical Therapy & Pilates, LLC.

Signature of Patient/Guardian:_____Date:_____

Relationship to Patient:_____

## Protected Health Information (PHI) Release Authorization

Persons who are involved in your care (spouse, children, friends, etc.) may inquire about your treatment, appointments, billing, medical records, etc. Please let us know below whom we may share your PHI with:

Name:_____ Phone:_____

Relationship:_____

Name:_____ Phone:_____

Relationship:_____

PLEASE NOTE THAT RE-FORM PHYSICAL THERAPY AND PILATES, LLC WILL ONLY RELEASE PHI TO THE INDIVIDUALS LISTED ABOVE.

I acknowledge in signing this document that I am giving Re-Form Physical Therapy and Pilates, LLC authorization to release or discuss PHI either in writing or verbally to the Persons specified above. This authorization is good indefinitely from the signature date below unless otherwise revoked by me in writing and a copy placed in my records.

Signature of Patient/Guardian:_____Date:_____

Relationship to Patient:_____

**1916 S. Carolina Street Ste. 100 | Amarillo, Texas 79102 | p: 806.803.9517 f: 806.803.9518**