290 Littleton Road, Suite 3
Chelmsford, MA 01824
Phone: 978-251-4860
Fax: 978-923-8655

Consent for Use and Disclosure of Protected Health Information

Purpose of Consent: *This Consent for the use and/or disclosure of personally identifiable health information is made pursuant to the requirements of 42 C.F.R. §164.506, which sets out the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").*

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Balanced Motion Physical Therapy, LLC. (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the regulations.
2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Consent, I understand and acknowledge that I have the right to review the Privacy Notice prior to signing this Consent.
3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 290 Littleton Road, Suite 3; Chelmsford MA 01824.
4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

   I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions): _
   ____
5. I understand and acknowledge that I may revoke this Consent at any time by sending a written revocation to the Practice at the address set forth in (3) above. However I also understand and acknowledge that if I revoke this Consent, my revocation will not be effective to the extent that the Practice has already acted action in reliance on this Consent.

I understand the foregoing provisions, and I wish to sign this Consent authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

Disclosure of Protected Health Information by Facsimile

Please read the following information carefully:

- I understand that one method of transfer of Protected Health Information (PHI) will be by facsimile (FAX).
- I understand that communication of PHI between health care providers and others may be necessary for the adequate and efficient treatment of patients. Records containing health information, history, symptoms, test results, diagnose, treatment and claims may be included.
- I agree that only representatives authorized by the Balanced Motion Physical Therapy, LLC. (the "Practice"), its agents and employees or its specified Business Associates and their agents and employees will request PHI or be provided with PHI to facilitate necessary communications.
- I understand and acknowledge that the PHI disclosed by the Practice will only be used for treatment, payment,health care operations and services.
- **I acknowledge that the facsimile machine receiving the PHI is in a protected area which limits access to authorized individuals only. I also acknowledge that all PHI received will be protected in accordance with application statutes and regulations, including, but not limited to the Privacy Regulations and applicable state and federal laws.**

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED THIS CONSENT AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

______________________________ Signature of Patient or Representative

______________________________ Patient's Printed Name

______________________________ Date

______________________________ Printed Name of Personal Representative (if applicable)

______________________________ Relationship to Patient

To Be Completed by Balanced Motion Physical Therapy, LLC.

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

_____ Accepted _____ Denied ____ Not Applicable ____Other***(explain)***______________________________

______________________________ Signature of Authorized Clinic Representative

______________________________ Date