South City Physical Therapy

ACKNOWLEDGEMENT
FOR RECEIPT OF
NOTICE OF INFORMATION PRACTICES

I have received or have been offered a written copy of South City Physical Therapy's Notice of Information Practices. I understand that South City Physical Therapy 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 in writing. I also understand that South City Physical Therapy will consider requests for restriction on a case by case basis but does not have to agree to requests for restrictions.

_____
Patient Name

_____
Signature

_____
Date