

Carnahan Therapy/The Work Center, Inc.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF INFORMATION PRACTICES

I have received and understand Carnahan Therapy/The Work Center Inc.'s Notice of Information Practices. I understand that Carnahan Therapy/The Work Center Inc. 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 Carnahan Therapy will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions for treatment, payment and operations purposes.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Carnahan Therapy The Work Center Inc.'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.

Print Name

Signature

Date

DESIGNATED INDIVIDUAL AUTHORIZATION FORM

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

This authorization remains in effect from the day of my initial evaluation _____ until 90-days after I have been discharged from Therapy for this condition.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature

Date

For Carnahan Therapy Office Use:

Y N Restriction on release of PHI. If yes, see attached form & mark outside of chart.

Y N Patient requests confidential communications. If yes, see attached form & mark outside of chart.

Checklist:

_____ Acknowledgement signed

_____ Date form signed in TA

_____ Charts stamped if restrictions on release or communication