



## Consent to Use and Disclose Health Information

I authorize Pantops Physical Therapy Services to use and disclose my personal health information for the purpose of Treatment, Payment and Health Care Operations.

**\*Treatment** includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician.

**\*Payment** includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilizations management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

**\*Health Care Operations** includes the necessary administrative and business functions for our office.

I further authorize Pantops Physical Therapy to use and disclose the following specific health and medical information for the below listed purpose(s):

Specific medical information consisting of: \_\_\_\_\_

For the specific purpose of: \_\_\_\_\_

I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that Pantops Physical Therapy has already used or disclosed the information in reliance on this Consent. Also by signing this I acknowledge that I have been given a copy of the Notice of Privacy Practices, which I am responsible for reviewing and inquiring questions about anything I do not understand.

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Signature of Patient

Date

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Signature of Privacy Officer

Date

