

## **The Physical Therapy Center of Cedar Rapids P.C. HIPAA Consent Form**

I have read and fully understand The Physical Therapy Center's Notice of Information Practices. I understand that The Physical Therapy Center 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 Physical Therapy Center in writing. I also understand that The Physical Therapy Center will consider my requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions pursuant to the law.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in The Physical Therapy Center's Notice of Information Practices. I understand that I retain the rights to revoke my consent by notifying The Physical Therapy Center in writing at any time.

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Patient Name

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Signature of Patient or Legal Guardian

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Date