Patient Information Consent

I have read and fully understand Theracare Outpatient Therapy Services (TOTS) Notice of Information Practices.
I understand that TOTS 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 corporation. I also understand that TOTS will consider requests for restriction on a case by case basis, but does not have to agree to requests to restrictions. I hereby consent to the use and disclosure of my personal health information for purposes noted in TOTS Notice of Information Practices.
I understand that I retain the right to revoke this consent by notifying the corporation in writing at any time.

Patient Name (Print) Date

Signature Date

Printed Name of Patient or Guardian (if under 18) Date

Signature of Parent or Guardian (if under 18) Date

I also authorize TOTS to use my protected health information for targeted marketing and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

Patient Name (Print) Date

Signature Date

Printed Name of Patient or Guardian (if under 18) Date

Signature of Parent or Guardian (if under 18) Date