ISLAND HEALTH PHYSICAL THERAPY
806 E MAIN ST
RIVERHEAD, NY 11901
Phone: (631) 591-3505
Fax: (631) 591-3503

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can be used and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple providers who may be involved in the treatment directly or indirectly.

2. Obtain payment from the insurance companies.

3. Conduct normal healthcare operations such as quality assessments and therapist's certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the disclosures of my health information. I understand that this office has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree you are bound to abide by such restrictions.

Patient Name: ____________________________

Relationship to Patient: ___________________

Signature: _______________________________

Date: ____/____/____

Office Use Only

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I attempted to obtain the patient' signature in acknowledgement of the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date Initials Reason