PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
STATEMENT OF PRIVACY NOTICE

We may disclose your health information:

1. To other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.
2. To your insurance provider for the purpose of payment or healthcare operations.
3. To comply with state Workers' Compensation laws.
4. To public health employees for preventing/controlling disease and reporting infectious exposures.
5. In the course of any administrative or judicial proceeding or law enforcement purposes.

Under the HIPAA federal privacy law you have the right to:

1. Request restrictions on certain uses and disclosures of health information.
2. Receive and account for or disclosure of your protected health information.
3. Inspect and copy your healthcare information.
4. A paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future. We are required by law to maintain the privacy of your health information.

If you have any questions regarding notice or if you want more information about your privacy rights, please contact us at 716-276-3567.

My signature indicates my authorization and consent for Buffalo-Niagara Physical Therapy to use and disclose my protected healthcare information for the purposes of treatment, payment, and healthcare operations as described above.

Print Name____

Signature____Date____________