HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature you acknowledge our notice of Privacy Practices and your right to review the Notice of Privacy Practices prior to signing this consent. A copy of the Notice of Our Privacy Practices may be obtained any time at the office or by forwarding a written request to:

Dr. James O'Rourke Physical Therapy
563 Park Street
Montclair, NJ 07043

Dr. James O'Rourke Physical Therapy reserves the right to revise its Notice of Privacy Practices at any time. If so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- If I do not sign this consent, Dr. James O'Rourke may decline to provide treatment to me.
- The practice may call my home or other designated location in reference to appointment reminders, insurance issues and any calls pertaining to my clinical care, including test results, etc.
- The practice may mail to my home/email or other designated location any items that assist in carrying out my treatment such as appointment reminder cards and patient statements.

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

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Patient Name (please print): ______________________________________ DOB: ______________

Signature:____Date:____________________

Print Name (If different from patient name):__________________________________

Relationship to patient (If Self please leave blank) ______________________________________