

## CONSENT AGREEMENT

*Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations*

I, \_\_\_\_\_ understand that as part of  
(Please Print Name Clearly)

my healthcare, Women First Rehabilitation, originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- . A basis for planning my care and treatment
- . A means of communication among the many health professionals who contribute to my care
- . A source of information for applying my diagnosis and medical information to my bill
- . A means by which a third-party payer can verify that services billed were actually provided,
- . A tool for routine healthcare operations such as assessing quality.

I understand and have been provided with a Notice of Privacy for Protected Health Information that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Women First Rehabilitation reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that Women First Rehabilitation is not required to agree to restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Women First Rehabilitation has already taken action in reliance thereon.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Physical Therapist

**Dr. Sara E. Bolden**

Physical Therapist / Women's Health Specialist

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