



NOTICE OF PRIVACY PRACTICES: Mountain States Hand and Physical Therapy (MSHPT) is required by law to protect the privacy of your personal health information. This is according to the Health Information Portability and Accountability Act (HIPPA) passed by Congress.

USES AND DISCLOSURES OF HEALTH INFORMATION:

- 1) With your permission, MSHPT will use your personal health information to provide treatment. This may include communication with other health professionals involved in your care (doctors, nurses, social workers etc.). We may also use your information to perform internal audits to insure quality of care. We may contact you regarding appointments, treatment, or other health related services that may be of benefit to you.
- 2) With your permission MSHPT will use your personal health information to obtain payment for your treatment.
- 3) We are required/permitted by law to disclose personal health information without your consent or authorization in the following circumstances:
 - ✓ Any required public health investigations
 - ✓ To workers compensation agencies to determine benefit eligibility
 - ✓ Information may be requested by intelligence activities if you are a member of the military
 - ✓ To law enforcement officials in reporting wounds injuries and crimes
 - ✓ To a court or discovery request
 - ✓ When we have provided health care to you at the request of your employer we may provide information to your employer
 - ✓ If we believe you have been a victim of domestic violence, neglect, abuse or if we suspect child abuse
 - ✓ Any other purpose required by law

YOUR RIGHTS REGARDING USE OF PERSONAL HEALTH INFORMATION:

- 1) You have the right to request restrictions on personal health information uses and disclosures
- 2) You have the right to request different ways to communicate information to you
- 3) You have the right to see and receive copies of your personal health information
- 4) You have the right to request an amendment to the personal health information about you
- 5) You have the right to file a complaint about the handling of your personal health information and our privacy practices
- 6) You have the right to a list of all the disclosures that we have made regarding your personal health information

CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION:

- I grant permission to Mountain States Hand & Physical Therapy, Inc. to disclose health information of the following individual: Patient Name: _____
I authorize the information to be disclosed as specified below:
- On my voicemail at home, work, cell (circle): _____ (phone #)
- To the following family member(s) or other person(s)
Name: _____
Relationship: _____ Phone #: _____
- The type and amount of information to be disclosed is as follows:
 - ANY information about the patient’s treatment
 - Appointment information ONLY
 - Other (specify): _____

I, _____ (print name) acknowledge that I have been advised in this clinics privacy practice and have received or been offered a copy of this notice.

Patient/Guardian Signature

Date

*****Please provide us with your email address so that we may send you a survey at the completion of your treatment. If you would prefer the survey mailed to you, please leave this blank: EMAIL: _____**