



Pillars Physical Therapy
and Wellness Center

2nd Floor, Suite D, 307 87th St.
87th Street Plaza, Daly City, CA 94015
(650) 550-0050

PATIENT CONSENT FORMS

I understand that I have certain rights to privacy with regard to my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent form I authorize you to use my protected health information to carry out the following:

- **Treatment** (*including direct or indirect treatment by other healthcare providers involved in my treatment*)
- **Obtaining payment from third party payers** (*e.g. my insurance company*)
- **Day to day healthcare operations of your practice**

I have also been informed of, and given the right to review an secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operation, but that you are not require to agree to these restrictions. However, if you do agree, you are then, bound to comply with these restrictions.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to date I revoke this consent will not affected.

PRINTED NAME: _____

SIGNATURE: _____

DATE: _____

RELATIONSHIP TO PATIENT: _____