ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As part of my health care, Oasis Therapy creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among Oasis Therapy personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and treatment to my bill.

I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for Oasis Therapy that provides a more complete review of information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices before signing this consent.

I understand that Oasis Therapy may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand Oasis Therapy for **Worker's Compensation Cases**, will release the minimum necessary PHI/ePHI to my employer, my worker's compensation insurance carrier, third party administrator, rehab nurse or nurse case manager unless otherwise restricted below.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that Oasis Therapy is not required to agree to the restrictions requested. The procedure to request **restriction** on information use and disclosure is contained in the Notice of Privacy Practices. Please complete the following that apply.

[__] I **DO NOT** authorize release of my information with the following individuals or organizations (enter names below and initial the box to left):

[__] I **DO** authorize sharing of my information with the following individuals or organizations (enter names below and initial the box to left):

[_____]
Spouse/Children:_____

[_____] Other:
_____

These restrictions and/or authorizations to release information will remain in effect until terminated in writing.

Appointment Communication Preference: I prefer to be contacted in the following manner:
[__] Home Phone [__] Work Phone [__] My Mobile Phone [__] Email

Provide email address or phone number:_____

I acknowledge that I have received a copy of the Notice of Privacy Practices of Oasis Therapy and that the full version is posted at my treatment facility and available upon request. I agree to the liability limitations explained therein.

_____ _____ _____
Signature of patient or legal representative Date Relationship to Patient

_____
Printed name of patient