Evolve Therapy & Associates

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Patient Consent Form and Acknowledgment of Receipt of Notice of Privacy Practices

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain healthcare providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical information and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we know are in need of your healthcare information and information about your treatment, payment or healthcare operations, in order to provide healthcare that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with clinicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to rescind all or part of your PHI. You may not revoke actions that have already been taken which rely on this or a previous signed consent.

I hereby acknowledge that I have had the opportunity to obtain and/or review a copy of Evolve Therapy and Associates Inc. Notice of Privacy Practices. I have the right to take a copy with me if I so choose. I have the right to request restrictions and revoke consent in writing after I have reviewed the privacy notice.

Patient's Name _____ Date _____

Signature _____ SIGN HERE