GIVEN
SPORTS & PHYSICAL THERAPY
EXPERTISE • EXPERIENCE • PERSONAL ATTENTION

Featuring McHenry County's First Board Certified Clinical Specialist

We are committed to providing quality healthcare services to you. An important part of that is facilitating various privacy rights that you have under Federal Law.

This document serves 2 purposes:

1. Acknowledgment by signature that the Notice of Privacy Practices has been made available for review. Signature indicates understanding and agreement with said Notice.
2. Instructions to request any restriction pertaining to the uses and disclosures of your protected health information ("PHI") that we may make for treatment, payment and operational reasons, as well as for other reasons provided for under applicable law.

Notice of Privacy Practices:

I understand the Notice of Privacy Practices (posted at www.givensportspt.com and available for review in the clinic itself) and consent to disclosure for permitted uses. I fully understand the terms of consent.

Patient Name: _____ **Date of Birth:** _____

Patient/Legal Representative Signature: _____ **Date:** _____

Restriction Request

Describe the PHI that you would like restricted including any individual(s), provider(s), insurance company(s) and/or other organization(s) that you would like to *prevent* from reviewing the designated PHI.

Detailed Description of restricted information: _____

Persons or Organizations Restricted: _____

It is our policy to process restriction requests within thirty days (30) of receipt. We will use the contact info that we have on file to: 1) follow-up with you for additional information if necessary; and/or 2) send you our written response to your request.

Patient Name: _____ **Date of Birth:** _____

Patient/Legal Representative Signature: _____ **Date:** _____

Authorization

Given Sports & Physical Therapy may release information regarding my treatment to the following individuals:

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

Patient Name: _____ **Date of Birth:** _____

Patient/Legal Representative Signature: _____ **Date:** _____

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