

AUTHORIZATION FOR OUTPATIENT TREATMENT

NAME: _____

The undersigned has been informed of the outpatient treatment considered necessary for the patient whose name appears above and that the treatment and procedures will be performed by McMeen Physical Therapy staff. Authorization is hereby granted for such treatment and procedures.

The undersigned has read the above authorization and understands the same and certifies that no guarantee or assurance has been made as to the results that may be obtained.

DATE: _____ TIME: _____ A.M. OR P.M.

SIGNED: _____ OR _____
Patient Authorized Person

WITNESS: _____

AUTHORIZATION FOR RELEASE OF THERAPY NOTES

I hereby authorize McMeen Physical Therapy to provide copies of my therapy records and notes as requested by my insurance company, attorney, or any other outside source representing me. I understand that a copying fee and postage may be assessed for these documents. I agree to be responsible for these fees in the event that the representing party's party prevents them from paying for this service.

DATE: _____ TIME: _____ A.M. or P.M.

SIGNED: _____ OR _____
Patient Authorized Person

WITNESS: _____

RECIPIENTS OF MY PERSONAL HEALTH INFORMATION

The following person(s) or organization(s) are authorized to receive my personal health information:

Name: _____ Relationship: _____
Name: _____ Relationship: _____

I understand that I may revoke this at any time by written notification.

DATE: _____ SIGNED: _____ WITNESS: _____

ACKNOWLEDGEMENT OR RECEIPT OF NOTICE OF PRIVACY

I have received McMeen Physical Therapy, P.C. *Notice of Privacy Practices* containing a more complete description of the used and disclosures of my health information. I understand that this organization has the right to change the *Notice of Privacy Practices* from time to time and that I may contact McMeen Physical Therapy, P.C. at any time to obtain a current copy of the *Notice of Privacy Practices*.

DATE: _____

SIGNED: _____

RELATIONSHIP TO PATIENT: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____