Palmetto Rehabilitation Specialists, LLC

PATIENT INFORMATION ACKNOWLEDGEMENT &Date: ____/____/____

DESIGNATED AUTHORIZATION

Patient Name:_____ DOB:_____

Patient Information Acknowledgement:

I have reviewed and fully understand Palmetto Rehabilitation Specialists' *Notice of Information PracticesandPatient's Rights*. I understand that PRS may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any additional administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal information is used and disclosed if I notify the practice in writing.

Consent of Treatment & Authorization to Release Information:

I hereby authorize PRS (through the appropriate personnel) to perform, or have performed upon me, or the above named patient, appropriate assessment and treatment procedures. I further authorize PRS to release any information acquired in the course of my, or the above named patient's examination and treatment, to the appropriate agencies.

Designated Individuals Authorization:

There may be times when it is necessary for an individual, other than yourself, to need access to your medical information. In order for that information to be released you must grant them authorization by listing their name and relationship in the designated space below. There will be no circumstance where your medical information is released, other than to appropriate agencies, without your written permission.

If you do not agree to grant access to anyone other than yourself and the appropriate agencies, please mark NONE. If you do wish to grant authorization to certain individuals, please fill in the information below.

Authorized Individuals:

_____NONE

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I hereby authorize the designated parties above to request/receive my protected health information which includes, but is not limited to, treatment notes, billing/payment records and any other administrative records related to my treatment. I understand that the identity of the designated parties will be verified before any information is released. I also acknowledge that any changes to this form must be made in person and in writing. I consent to the use and disclosure of my personal health information as note in the *Notice of Information Practices*. I understand that I retain the right to revoke this consent at any time by notifying PRS staff in writing.

Patient Signature:_____ Date:_____

Guarantor's Signature (if patient is a minor):_____