Prime Physical Therapy
1161 NE Rice Rd
Lee's Summit, MO 64086
P) 816-402-2178
F) 816-600-2278

HIPAA Privacy Authorization

Authorization for Use or Disclosure of Protected Health Information

I authorize Prime Physical Therapy to disclose my medical and health information. This information will be used by Prime Physical Therapy, or may be disclosed to others as appropriate, for the purpose of obtaining information regarding medical treatment, the day-to-day health care operation, consultation, billing and claiming payment, or other purposes as I may direct.

We are providing you with a copy of our Notice of Privacy Practices. I understand that I have the right to revoke this authorization at any time. If you wish to restrict your disclosure, you should make that request in writing. I understand that a revocation is not effective to the degree that any person or entity has already acted in reliance on my authorization or if my authorization was acquired as a condition of attaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

This practice reserves the right to modify the privacy practices outlined in the notice.

HIPAA Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient/ Legal Guardian Signature: ____

Date: ______________________________________