



**Consent to the Use and Disclosure of Health  
Information for Treatment, Payment, or  
Healthcare Operations**

I, \_\_\_\_\_, understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been made aware of the Notice of Information Practices on file and I have the right to review that Notice if I desire.

The following persons listed are allowed to obtain treatment information and/or billing information associated with my treatment at Stodden Physical Therapy, LLC:

Spouse: Yes No Name: \_\_\_\_\_ Parent: Yes No Name: \_\_\_\_\_  
Employer: Yes No Name: \_\_\_\_\_ Child Yes No Name: \_\_\_\_\_  
Other: Yes No Name: \_\_\_\_\_ Child Yes No Name: \_\_\_\_\_

If I am unable to be reached, I give permission to have messages regarding my appointment time, changes of, or scheduling information left as follows:

\_\_\_\_ on answering machine \_\_\_\_ on voice mail \_\_\_\_ with family member \_\_\_\_ at work

I fully understand and accept the terms of this consent.

Signature \_\_\_\_\_

Date \_\_\_\_\_