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**WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND  
CONSENT FOR USE AND DISCLOSURE OR PROTECTED HEALTH INFORMATION**

I acknowledge receipt of the physical therapist's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I hereby give my consent for Adel Physical Therapy, Inc. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Adel Physical Therapy's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Adel Physical Therapy, Inc. reserves the right to revise its Notice of Privacy Practices at any time. I understand that a revised Notice of Privacy Practices will be provided to me and posted in the office.

With this consent, Adel Physical Therapy, Inc. may call my home or other alternative location and leave a message on voice mail or in person to a spouse or family member in reference to any items that assist the practice in carrying out TPO. This may include such things as appointment reminders, insurance items and billing issues.

With this consent, Adel Physical Therapy, Inc. may email to my home or other alternative location any items that assist the practice in carrying out TPO.

I have the right to request that Adel Physical Therapy, Inc. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Adel Physical Therapy, Inc. use and disclosure of my PHI to carry out TPO.

I understand that this consent is valid until it is revoked by me. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Adel Physical Therapy, Inc. may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
If legal guardian, indicate  
relationship to patient