



**COPPOLA PHYSICAL THERAPY**

**CONSENT TO USE PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPTION**

I consent to allow Coppola Physical Therapy to use or disclose my protected health information for treatment, payment and health care operations

- Treatment means the provision, coordination, or management of health care and related services by one or more health care providers.
- Payment means the activities undertaken by a health care provider or health plan or obtain or provide reimbursement for the provision of health care.
- Health care operations means the conduction quality assessment and improvement activities; reviewing the competence or qualifications of health care professionals; underwriting, premium rating, and other activities related to health insurance contracts; medical reviews; legal services; auditing functions; and business management and general administrative activities of Coppola Physical Therapy.

I consent to allow Coppola Physical Therapy to disclose my protected health information to another covered entity for health care operations activities, provided that Coppola Physical Therapy and the other covered entity has or had a relationship with the below named patient. The disclosure must be treatment, payment, or health care operations related, or for the purpose of health care fraud and abuse detection or compliance.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Patient/Authorized Representative      Name of Patient (Please Print)      Date

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**Acknowledgement of receipt of HIPPA notice**

Coppola Physical Therapy is concerned about the privacy of our patient’s health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

I acknowledge that I have read the Notice of Privacy Practice and if I wish to obtain a copy if my own, one shall be provided by Coppola Physical Therapy upon my request.

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Signature of Patient/Authorized Representative      Name of Patient (Please Print)      Date