



## PATIENT INFORMATION CONSENT FORM

I have ready and fully understood the TheraMAX Rehabilitation & Sports Physical Therapy, PLLC Notice of Information Practices. I understand TheraMAX Rehabilitation & Sports Physical Therapy, PLLC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluation of the quality of service provided and any administrative operations relates to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the requests for restriction on a case-by-case basis, but does not have to agree to request for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in TheraMAX Rehabilitation & Sports Physical Therapy, PLLC Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

PATIENT NAME \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_