REHAB AT WORK
It's Our REHAB That WORKS
Via Web Site

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name: _____

Address: _____ City, State, Zip: _____

Phone: _____ SSN: _____

PLEASE READ THE FOLLOWING STATEMENTS

Purpose of Consent: By signing this form, you agree to consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign the Consent form. Our notice provides a description of our treatment, payment activities, and healthcare operation, of the uses and disclosures we may make of your protected health information, and any other important matters about your protected health information. A copy of our Notice is available for you to review at your request. If you choose, we encourage you to read it carefully and completely before signing this Consent form.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by written request to our Privacy Officer at our corporate office.

Right to Revoke: You will have the right to revoke this Consent at any time by giving REHAB AT WORK written notice of your revocation. Please understand that revocation of this Consent will not affect any action we have taken regarding reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent. _____

AGREEMENT TO CONSENT

I, _____, have had full opportunity to read and consider the contents of this Consent Form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

_____ _____
Signature of Patient **Date**

If a personal representative on behalf of the patient signs this Consent, please complete the following:

_____ _____
Representative's Name **Relationship to Patient**