**Hands On Therapeutics**

Notice of Privacy Practices

This notice describe how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Hands on therapeutics/West Physical Therapy is required to maintain the privacy of your Protected Health Information (PHI) and to provide you with a notice of our legal duties and privacy practices with respect to PHI. PHI is information about you, including basic demographic information, that my identify you and that relates to your past, present or future physical or mental health or condition and related health care services. This Notice of Privacy Practices (Notice) describes how we may used and disclose PHI about you to carry out treatment, payment or health care operations and for other specified purposes that are permitted or required by law. The notice also describes your rights with respect to PHI bout you.

1. \_\_\_\_\_\_\_\_**Uses and Disclosures**

**Hands on Therapeutics/West Physical Therapy** will use your protected health information (PHI) for the purpose of treatment, payment and health care operations.

**Treatment** includes the disclosure of health information to other providers who have referred you to West Physical Therapy for services or involved in your case. This may include physicians, nurses, case managers and/or other physical therapists.

**Payment** includes the disclosure of health information to your insurance company, including Medicare, so payment can be obtained for our services rendered. Your insurance company my request to review your medical record to determine that your care was necessary.

**Health Care Operation** includes the utilization of your record to monitor quality care being given at our facility or business operations.

1. \_\_\_\_\_\_\_\_**Hands on Therapeutics /West Physical Therapy** may use your PHI to contact you about an appointment and to inform you of our other health related products and services.
2. \_\_\_\_\_\_\_\_ **Uses and Disclosures Required by Law**

The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways:

We may share some of your PHI with a family member or friend involved in your care if you do not object, we may use you PHI in an emergency situation with you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions. We may also use and disclose health information about you to avert a serious threat to your health or safety to the public. We may release information about you for workers’ compensation or other similar programs that provide benefits for work related injury or illness.

Your authorization is required before your PHI may be used or disclosed by us for other purposes.

1. \_\_\_\_\_\_\_\_ Your Privacy Rights

**Restrictions**: you have the right to request restrictions on how your PHI is used. We are not required to agree

with your requests. If we do agree, we must abide by your request or be held accountable

**Confidential Communications:** You have the right to request confidential communication from us at a location of

your choosing. This request needs to be filed in writing to West Physical Therapy. We will accommodate all

reasonable requests.

**Access to PHI**: You have the right to request a copy of your medical record. You must make this request in writing and we will charge a fee to cover the costs of copying and mailing.

1. \_\_\_\_\_\_\_\_ **Media Release**: I grant permission for Hands on Therapeutics to use any photo or video footage for any Hands on Therapeutics media publications. You may send me email confirmations. Emails about my health, therapeutic exercises, home Exercise programs, or Hands on Therapeutics Service/Program information.

Print Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature or legal guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_