HANDS ON HEALING
Physical Therapy Center

Acknowledgment of Receipt of Notice of Privacy Practices

A copy of the Notice of Privacy Practices for Hands on Healing Physical Therapy was given or made available to me. Hands on Healing Physical Therapy reserves the right to modify the privacy practices outlined in the notice.

_____ _____
Signature of Patient Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form.)

_____
Relationship of Patient Representative to Patient

Request for Non-Disclosure

Information involving you may be released to a family member, other relative or close friend if we believe it is for your best interest. We will use only health information that is relevant to that person's involvement in your care. If in the event we need to discuss your care with a family member, other relative or close friend, is there anyone you object this information being disclosed to?

DO NOT release any medical information about my care to the following family members or close friends:

_____

_____

_____

_____ _____
Signature of Patient Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form.)

_____
Relationship of Patient Representative to Patient