

PRIVACY POLICY

WE AT GAINESVILLE PHYSICAL THERAPY WILL NOT RELEASE ANY INFORMATION ABOUT YOU TO ANYONE OTHER THAN YOUR REFERRING PHYSICIAN OR YOUR INSURANCE COMPANY WITHOUT YOUR WRITTEN CONSENT.

By signing below, I acknowledge that I have read and understand
Gainesville Physical Therapy's Privacy Notice.

Printed Name of Patient or Patient's Representative

Signature of Patient or Patient's Representative

Date

Representative's Relationship to Patient (if applicable)

To be completed by Gainesville Physical Therapy Staff
↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓

Are there any Privacy Issues?

Office Staff → Please initial Yes or No

_____ NO

_____ YES

* If "YES" please have patient complete appropriate Patient's Rights Form(s) and place in patient's chart

Clinical Staff → Please initial YES or NO

_____ NO

_____ YES

-
- After a good faith attempt to obtain an Acknowledgment of receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason(s):

Signature of Gainesville Physical Therapy Representative

Date