**HIPPA Notice of Privacy Practices**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have been provided with Peak Physical Therapy’s policy for Protected Health Information at the new patient appointment. The HIPPA notice describes use and disclose your PHI to carry out treatment, payment, and healthcare operations. I have signed this form showing that I agree with the use of my PHI and have indicated on my demographics sheet how to contact me.

**I may revoke any rights to my Protected Health Information in writing at any time.**

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Signature date