Nebraska
Orthopaedic
Physical Therapy, P.C.

HIPAA and Communication Authorization Form

Patient Name: _____ SSN _____

I have read and understand the HIPAA NOTICE OF PRIVACY PRACTICES provided to me by Nebraska Orthopaedic Physical Therapy P.C. This notice describes how my medical information may be used and disclosed and how I can get access to the information. I understand that a copy will be provided to me upon request.

_____ _____
Name date

The Physical Therapists at Nebraska Orthopaedic Physical Therapy, P.C. strive to communicate with each patient in an effective and professional manner. Our policy states that all communication between you and your therapist is completely confidential. However, there may be some cases that your family member, friend, or others might be involved with your care as a patient and you may want us to communicate directly with them. In order to follow our policy and protect the privacy of your personal health information, please list any and all names of people with whom your therapist can discuss your health information with.

Name_____Relation_____

Name_____Relation_____

Name_____Relation_____

Name_____Relation_____

I fully understand that the people above can receive my private health information if needed.

Date Patient Signature Guardian Signature(if needed)