Patient Name:

KASSIMIR PHYSICAL THERAPY, PA
HIPAA INFORMATION

THIS FORM IS NOT TO BE ALTERED BY PATIENT/REPRESENTATIVE FOR ANY REASON

The Health Insurance Portability and Accountability Act (HIPAA) was created to protect an individual's medical records and other personal health information by adhering to national standards. This act gives patients more control over their health information, sets boundaries for the use of records, and establishes safeguards to protect information.

Your information may be released by Kassimir Physical Therapy, P.A., to any of the following:

- Other medical providers
- Attorneys
- Department of Health & Human Services
- HIPAA regulators
- Power of attorney
- Guardian (if patient is a minor)
- Social Security Administration
- **In addition to the above listed entities**, you may assign a Health Information Agent (spouse, relative, or friend) who may be able to contact us on your behalf (to schedule appointments, request records, etc.)

******** PLEASE LIST SOMEONE OTHER THAN YOURSELF BELOW********

NAME: (please print) _____ **Relationship to you:** _____

NAME: (please print) _____ **Relationship to you:** _____

Our office has implemented safeguards to protect your health information. We have privacy sign-in sheets, chart holders that conceal the patients' names, software that complies with HIPAA privacy standards, and passwords on all computer systems. We also have private evaluation rooms for all initial appointments to prevent disclosure of your history to others in the office. *There are complaint forms available for you to utilize if you see a violation of patient privacy. It will be addressed by Centers for Medicare & Medicaid.*

For more information about HIPAA, log onto: www.hhs.gov/ocr/hipaa or www.cms.hhs.gov/hipaa.

I acknowledge receipt of this information pertaining to my medical information and any questions asked have been answered.

_____ _____

Patient Printed Name Date

_____ _____

Patient Signature Witness Initials