

# **BreakThrough**

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## **PHYSICAL THERAPY**

*Newest Research, Fewest Visits, Best Results*

### **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Carteret Physical Therapy Associates, Inc, and/or BreakThrough Physical Therapy, Inc. reserves the right to modify the Privacy Practice Notice to reflect HIPAA Regulatory changes.

**Signature Of Provider:** \_\_\_\_\_

**I have received a copy of the Notice of Privacy Practices for Carteret Physical Therapy Associates, Inc and/or BreakThrough Physical Therapy**

\_\_\_\_\_  
Name of Patient (Print or Type)

\_\_\_\_\_  
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

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I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information occurs.

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

# **BreakThrough**

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## **PHYSICAL THERAPY**

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### Consent to Use and Disclosure of Protected Health Information

#### **Use and Disclosure of Your Protected Health Information**

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Your protected health information will be used by Carteret Physical Therapy Associates, Inc and/or BreakThrough Physical Therapy or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

#### **Practices Notice of Privacy**

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You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

#### **Requesting a Restriction on the Use or Disclosure of Your Information**

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You may request a restriction on the use or disclosure of your protected health information. Carteret Physical Therapy Associates, Inc and/or BreakThrough Physical Therapy may or may not agree to restrict the use or disclosure of your protected health information. If Carteret Physical Therapy Associates, Inc and/or BreakThrough Physical Therapy agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

#### **Revocation of Consent**

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You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

#### **Reservation of Right to Change Privacy Practices**

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Carteret Physical Therapy Associates, Inc and/or BreakThrough Physical Therapy reserves the right to modify the privacy practices outlined in the notice. You can request a current privacy policy by calling 252-247-2738.

#### **Signature**

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I have reviewed this consent form and give my permission to Carteret Physical Therapy Associates, Inc and/or BreakThrough Physical Therapy to use and disclose my health information in accordance with it.

\_\_\_\_\_  
Name of Patient (Print or Type)

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient Representative/ Relationship to patient

2828 Maplewood Ave., Ste A  
Winston-Salem, NC 27103  
336-765-4703

3700 Symi Circle  
Morehead City, NC 28557  
252-247-2738

1910 N Church St., Ste D  
Greensboro, NC 27405  
336-274-7480

530 Sandhurst Dr.  
Fayetteville, NC  
910-483-9300