

Baxter & Walsh Physical Therapy

PATIENT INFORMATION CONSENT FORM

I have read and fully understand **Baxter & Walsh Physical Therapy's** Notice of Information practices. I understand that **Baxter & Walsh Physical Therapy** may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluation of the quality of services provided and any administrative operation related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that **Baxter & Walsh Physical Therapy** will consider requests for restriction on a case-by-case basis, but does not have to agree to requests or restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in **Baxter & Walsh Physical Therapy's** Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name (Print)

Date

Patient Signature

Signature of Parent or Guardian