



Flow Physical Therapy

HIPAA Privacy Notice

Patient Information

Patient Name: _____

Date of Birth: _____

HIPAA Privacy Notice

At **Flow Physical Therapy**, we are committed to protecting your personal health information in compliance with the **Health Insurance Portability and Accountability Act (HIPAA)**. This notice describes how your medical information may be used and disclosed and how you can access this information.

How We May Use and Disclose Your Health Information

We may use and disclose your health information for:

- Treatment** – To provide, coordinate, or manage your care with healthcare providers.
- Payment** – To obtain payment from insurance providers or third parties for services rendered.
- Healthcare Operations** – For quality assessment, training, compliance audits, and other healthcare-related activities.

Other disclosures may include:

- Required by law** (e.g., public health reporting, abuse/neglect cases, law enforcement requests)
- Family or caregivers** involved in your care (with your consent)
- Appointment reminders and follow-up communications**

Your Rights Regarding Your Health Information

As a patient, you have the right to:

- Request a copy of your medical records (fees may apply).

- Request corrections to your health information.
- Restrict certain disclosures of your health information.
- Request confidential communication.
- File a complaint if you believe your rights have been violated.

You may request more details about our full **Notice of Privacy Practices** at any time.

Patient Consent for Use and Disclosure of Information

I acknowledge that I have received and reviewed **Flow Physical Therapy's Notice of Privacy Practices**. I understand that my health information may be used and disclosed for treatment, payment, and healthcare operations.

I also understand that I have the right to restrict the use and disclosure of my health information and that **Flow Physical Therapy** is not required to agree to requested restrictions.

I give consent for Flow Physical Therapy to contact me via:

Phone Call Text Message Email

I authorize Flow Physical Therapy to leave messages regarding my care at my listed phone number.

I authorize Flow Physical Therapy to discuss my medical information with:

Name: _____ **Relationship:** _____

I understand that I can revoke this consent in writing at any time.

Signature & Acknowledgment

By signing below, I confirm that I have read and understand the **HIPAA Privacy Notice** and I agree to the terms outlined above.

Patient Signature: _____

Date: _____

Parent/Guardian Signature (if applicable): _____

Date: _____

