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Privacy Practices Acknowledgement and Consent Form

- ❖ I have received your Notice of Privacy practices and/or I have been provided an opportunity to review it.
- ❖ I agree that telephone messages regarding my appointments, prescription renewals, lab results, and all other Protected Health Information* (“PHI”), may be left for me on voicemail systems and answering machines at the following telephone numbers, in addition to any other numbers provided to you by me:

(___) ___ - ____	Home/ Office/ Cell/ Other: _____
(___) ___ - ____	Home/ Office/ Cell/ Other: _____
(___) ___ - ____	Home/ Office/ Cell/ Other: _____

- ❖ I agree that my PHI may be shared with my spouse (if applicable).
- ❖ I agree that my PHI may be shared with my other medical providers.
- ❖ I agree that my PHI may be shared with the following other people:

- ❖ I understand that I can change any of the foregoing agreements, at any time, by giving written notice to Progressive Hand Therapy to the attention of the HIPAA Compliance Officer.
- ❖ I agree that Progressive Hand Therapy may contact me at any email addresses provided to you by e regarding both PHI and non-PHI.

*as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time-to-time (“HIPAA”)

Patient Name (Please print clearly): _____

Signature of Patient or Guardian: _____ Date: _____