Acknowledgement of Receipt of Notice of Privacy Practices

Rivera Physical Therapy, P.C. reserves the right to modify the privacy practices outlined in the notice.

I have hereby received a copy of the Notice of Privacy Practices for Rivera Physical Therapy, P.C.

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Name of Patient (print or Type)

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Signature of Patient

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Date

____

Signature of Patient Representative
(Required if patient is a minor or an adult who is unable to sign this form)

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Relationship of Patient Representative to Patient

Consent to release my personal health information to the following individuals?