**ACHIEVA REHABILITATION, LLC**

**CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION**

Your protected health information will be used by this practice, known as ***Achieva Rehabilitation, LLC*** or disclosed to others for the purposes of treatment, obtaining payment or supporting the day-to-day health care operations of the practice. We are providing you with a copy of our Notice of Privacy Practices. We request that you review the notice prior to signing this consent.

You may request a restriction on the use or disclosure of your protected health information. If you should wish to restrict your disclosure, you should make the request in writing. This practice however, may or may not agree to restrict the disclosure of your protected health information.

If we agree to your request, the restriction will be binding. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

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 of your revocation of consent is received will not be affected. This practice reserves the right to modify the privacy practices outlined in the notice.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize this medical practice,***Achieva Rehabilitation****,****LLC,***  to disclose, the information listed, to the individuals listed below. I understand that information disclosed to this (these) individual(s) may re-disclose information inadvertently to other parties. The privacy of this information may not be protected under the federal privacy regulations. This practice does not take responsibility for any disclosure made by the individual(s) listed below. You may revoke or terminate this authorization by submitting your request in writing. Please contact the Privacy Officer if you should wish to terminate or change this authorization at a later date.

ALL of my Protected Health Information may be given/released to:

* Only Myself
* Spouse / Significant Other: Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Children: Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

* Other: Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**SIGNATURE**

**I have reviewed this consent form and have reviewed the Notice of Privacy Practice. I give my permission to this practice to use and disclose my health information in accordance with it.**

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**Name of Patient (Print Clearly)**

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**Signature of Patient Date**

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**Signature of Patient Representative Relationship to Patient**