The Sigurd Center for Orthopedic & Neurological Rehabilitation
1311 Augusta Road West Columbia, SC 29169
P: 803.926.7204 F: 803.926.7206
www.sigurdphysicaltherapy.com

Patient Authorization to Release Protected Health Information to The Sigurd Center for Ortho & Neuro Rehabilitation

With my consent, The Sigurd Center for Orthopedic & Neurological Rehabilitation may use and release protected health information {PHI} about me to perform treatment, obtain payment and carry out healthcare operations.

With my consent, The Sigurd Center for Orthopedic & Neurological Rehabilitation can call, mail or email me in reference to any item that will assist the facility in performing facility operations. These operations may include appointment reminders, insurance information or other information pertaining to my clinical care. I have the right to ask that The Sigurd Center for Ortho & Neuro Rehab limit how it uses my PHI in order to perform the facilities operations. However, the facility is not required to agree to my restrictions, but if it does, it is bound by the agreement.

By signing this form, I_____am consenting to The Sigurd Center for Orthopedic & Neurological Rehabilitation to use and disclose of my PHI to perform the facilities operations, as well as, acknowledging that I have received and reviewed a copy of the Notice of Privacy Practices. I may cancel my consent in writing except to the degree that the facility has already made disclosures in reliance upon my prior consent. If I refuse to sign this consent form, the Sigurd Center for Orthopedic & Neurological Rehabilitation may decline to provide treatment for me.

Any patient may request and receive a copy of their medical records. It could take up to 72 hours and there may be a fee charged for this service.

Patient Signature:_____ **Date**:_____

Please choose an option below and sign:

I_____, do not wish to receive a copy of this privacy policy.

I_____, wish to receive a copy of this privacy policy.