MONTCLAIR
PHYSICAL THERAPY & WELLNESS
6125 Medau Place ■ Oakland, California 94611 ■ 510.339.2116 ■ Fax: 510.339.0647 ■ www.montclairpt.com ■ clinic@.montclairpt.com

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by ***Montclair Physical Therapy & Wellness*** (***MPTW***) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of ***MPTW***. I understand that diagnosis or treatment of me by ***Chris Ernst MSPT, Ginny Bruington MSPT, Leah Saldua PT, Simon Gibson PT, or any other licenses Physical Therapist employed by MPTW*** may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. ***MPTW*** is not required to agree to the restrictions that I may request. However, if ***MPTW*** agrees to a restriction that I request, the restriction is binding on ***Montclair Physical Therapy & Wellness*** and ***Chris Ernst MSPT, Ginny Bruington MSPT, Leah Saldua PT, Simon Gibson PT, or any other licenses Physical Therapist employed by MPTW.*** I have the right to revoke this consent, in writing, at any time, except to the extent that ***Chris Ernst MSPT, Ginny Bruington MSPT, Leah Saldua PT, Simon Gibson PT, or any other licenses Physical Therapist employed by MPTW*** or ***MPTW*** has taken action in reliance on this consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me (or there is a reasonable basis to believe the information may identify me). I understand I have a right to review ***MPTW's*** Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of ***MPTW***. This Notice of Privacy Practices also describes my rights and ***MPTW*** duties with respect to my protected health information. ***MPTW*** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient/Personal Representative	**Name of Patient/Personal Representative**
Date	**Description of Personal Representative's Authority**