Acknowledgement of Receipt of Privacy Notice

I _____ acknowledge I have received and reviewed the privacy notice of Mackarey and Mackarey Physical Therapy Consultants, LLC.

Date: _____

Signature: _____
Patient Signature

Witness: _____ Date: _____

Legal Guardian: _____ Date: _____
Name

Relationship: _____

General Medical Release

This is a general release for the purpose of treatment, payment and health care operations only. **The general release does not allow release of any information other than that identified in this notice.** We request that you sign this general release prior to treatment being rendered. If you fail to sign the release, MMPTC reserves the right to limit or discontinue treatment. You have the right to limit or rescind the release of **all** medical information. MMPTC is not required to agree to the requested restriction and MMPTC retains the right to review your care for further treatment. In all cases, MMPTC will retain the right to release your information for payment, treatment and operations rendered prior to the receipt of such restriction.

I _____ give my permission for Mackarey and Mackarey Physical Therapy Consultants, LLC to release my health care information as outlined in the privacy notice for the purpose of treatment, payment and health care operation.

Date: _____

Signature: _____
Patient Signature

Witness: _____ Date: _____

Legal Guardian: _____ Date: _____
Name

Relationship: _____

Please indicate your preferred method of contact, or if you wish to give permission to release information about your care or appointments to another individual, such as your spouse, children or an attorney.

Leave appointment message on:

	Yes	No
Home Phone	☐	☐
Cell Phone	☐	☐
Office Voicemail	☐	☐
With another person	☐	☐
Via US Mail	☐	☐
Via E-Mail	☐	☐

Leave other medical information on:

	Yes	No
Home Phone	☐	☐
Cell Phone	☐	☐
Office Voicemail	☐	☐
With another person	☐	☐
Via US Mail	☐	☐
Via E-Mail	☐	☐

If you have indicated that we may contact another person regarding your care or appointments, please write the name(s) of the individual(s) below. Check the box before the name if any individual is your emergency contact.

	Name	Relationship	Phone #
☐ Emergency contact			
☐ Emergency contact			
☐ Emergency contact			
☐ Emergency contact			
☐ Emergency contact			
☐ Emergency contact			

Signature: _____ Date: _____

(This authorization will expire at end of treatment or upon notification of change from the patient)