CONSENT AGREEMENT

St. George Physical Therapy is in compliance with HIPAA regulations, and therefore, will not use or disclose health information for any purpose other than treatment or payment or healthcare operations related to treatment and payment.

You may ask to have your health information restricted. However, if such restriction interferes with obtaining payment from your insurance carrier, you will be fully responsible for payment at the time of services.

Please sign below to show your consent for the following:

- **I consent to allow St. George Physical Therapy to provide treatment.**
- **I consent to allow St. George Physical Therapy to release any personal or medical information acquired in the course of such treatment or examination to my referring physician and/or to my insurance carrier covering this treatment.**

If you wish the release of your health information to any other entity, please print their name/names below with their address. Please note that there is a charge for medical records sent to anyone other than your referring physician and/or your primary insurance carrier.

Information Needed	Person/Persons Info to be Sent to	Address	Date

I hereby acknowledge receipt of St. George Physical Therapy's policy sheet and privacy practices.

Patient/Guardian Name_____ **Date**_____