ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the WESTARM Therapy Notice of Privacy Practices (hereafter referred to as "Notice"). I understand that the information the office of WESTARM Therapy acquires or creates about me will only be disclosed to others for treatment, payment and healthcare operations as set forth in the "Notice", or as authorized by me in writing.

______________________________	______________________________
Signature of Patient (or substitute decision maker)	Signature of Witness
______________________________	______________________________
If substitute decision maker, state relationship	Date

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I also understand that if the organization authorized to receive the information is not a health plan or health care provider, the release information may no longer be protected by federal privacy regulations and that it may be re-disclosed by the recipient.

Patient Name: ______________________________

Organization Providing the Information:
WESTARM Therapy

Organization(s) or Person(s) Receiving the Information:
Primary Care Physician, Specialist Physician, Insurance Company

Other as designated by patient / guardian: ______________________ Relationship: __________

Specific Description of Information Disclosed:
Information to be released will include pertinent PT/OT initial evaluation, daily progress notes, re-assessments, discharge summaries, physician reports, prescriptions and daily charge information.

Purpose of Disclosure:

- Communication of pertinent patient treatment information between physician and clinician.
- Communication of pertinent patient treatment information between WESTARM Therapy and insurance carriers for payment purposes.

PLEASE READ AND SIGN THE FOLLOWING STATEMENTS:

I understand this Authorization will expire 1 year after discharged from treatment. I also understand that I may revoke this Authorization at any time by notifying WESTARM Therapy Services in writing.

______________________________	______________________________
Signature of Patient (or substitute decision maker)	Signature of Witness
______________________________	______________________________
If substitute decision maker, state relationship	Date