



401 South Pasadena Avenue
St. Petersburg, FL 33707
Phone: 727-384-4600
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CONSENT FOR TREATMENT

I consent to the use or disclosure of my protected health information by **Seabreeze Physical Therapy, Inc.** For the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations by **Seabreeze Physical Therapy, Inc.** Therefore I authorize, by my signature on this document, by **Seabreeze Physical Therapy, Inc.** to evaluate and treat my condition. I understand that diagnosis or treatment of me by **Seabreeze Physical Therapy, Inc.** and/or its employees may be conditioned upon my consent.

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. **Seabreeze Physical Therapy, Inc.** is not required to agree to the restrictions that I might request. However if **Seabreeze Physical Therapy, Inc.** agrees to a restriction that I request, the restriction is binding on **Seabreeze Physical Therapy, Inc. and any employee of that entity.**

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, mental health condition, and identifies me, or there is a reasonable basis to believe the information may identify me.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Seabreeze Physical Therapy, Inc.** has taken action in reliance to this consent.

I understand I have the right to review **Seabreeze Physical Therapy, Inc.'s** Notice of privacy practices prior to signing this document. The notice of privacy practices will be (upon Request) provided to me. The notice of privacy practices is also located in the waiting area where found in a 3 ring binder notebook.

Seabreeze Physical Therapy, Inc. reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices.** I may obtain a revised notice by calling the Office Manager at (727) 384-4600 and requesting a revised copy.

Signature of patient or personal representative

Date

Print name of Patient or personal representative

Seabreeze Physical Therapy, Inc Authorized Representative

Date