MADISON MEDICAL & SPORTS rehabilitation center
AN INTEGRATIVE MEDICAL SERVICES CO.

Last Name:	First Name:	DOB:

Healthcare Portability and Accountability Act (HIPAA) Designation of Disclosure

Madison Medical & Sports Rehabilitation Center may share my personal health information (PHI) for the purposes of my treatment, to obtain payment or for internal quality assessment. We cannot give information for any other purpose without specific authorization by you. Persons under the age of 10 may have their information shared with the parent of legal guardian without written consent except for information pertaining to sexually transmitted diseases. Certain medical emergencies may necessitate release of your medical information to someone not listed in this release. Information requested during a criminal investigation is not bound to this release.

I give my permission allowing Madison Medical & Sports Rehabilitation Center to discuss my PHI with the following individuals:

Name	Relationship	Contact Number

_____ (Please initial) I do not release my information to anyone except for required purposes as outlined above.

Please initial one of the following statements.

_____ We will make every attempt to reach you directly, however in the event we cannot, please list contacts for us to leave a message.

Contact Number: □ Home □ Work □ Mobile

_____ I do not want a message left at any contact number. I understand this may delay in the communication of critical health information and delay treatment or diagnosis.

Patient Valuables Waiver

_____ (Please initial) I understand that Madison Medical & Sports Rehabilitation Center does not assume any responsibility for any articles of clothing, money, jewelry, or personal items including keys and eyeglasses.

Acknowledgement of Receipt of Patients' Rights and Notice of Privacy

Please initial	
	I confirm I have been provided information on my rights and responsibilities. I have been given the opportunity to ask questions and request a copy for my files.
	I confirm I have been provided information on Madison Medical & Sports Rehabilitation Center's Notice of Privacy Practices. I have been given the opportunity to ask questions and request a copy for my files.

Advance Directive Policy Confirmation

Please initial all that apply	
	I am aware that I may provide the practice with a copy of my advance directive for my permanent medical record. Care, service, and treatment provided in this practice is of the outpatient nature. In the event, of a transfer a copy will be sent to the acute care facility.
	I have provided Madison Medical & Sports Rehabilitation Center a copy of my advance directive.
	I have an advance directive but choose not to provide a copy to Madison Medical & Sports Rehabilitation Center.
	I do not have an advance directive. I am aware that I can request information about an advance directive.

_____

Print Patient Name — Print Name of Guardian if applicable

_____

Patient or Guardian Signature — Date