Divine
Therapy & Wellness, LLC.
Striving for Excellence in Rehabilitation Care

Divine Therapy & Wellness, LLC.
3300 SW 34th Ave. Suite 124B
Ocala, FL 34474
Phone: (352) 562-7772
Fax: (321) 400-1422
Toll Free: 1-877-658-1433
E-Mail: PT@divinetherapyandwellness.com
www.divinetherapyandwellness.com

PATIENT HIPAA AWARENESS AGREEMENT

With my permission, ***Divine Therapy & Wellness*** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to ***Divine Therapy & Wellness*'s** Notice of Privacy Practices for a more complete description of such uses and disclosures.

A copy of the Notice of Privacy Practices was made available to me prior to signing this consent. The Practice reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the offices of ***Divine Therapy & Wellness*** may call my home or other designated locations and leave a message on voicemail, or in person, in reference to any items that may assist The Practice in carrying out TPO, such as appointment reminders, insurance matters and any information pertaining to billing/collections or my clinical care, including laboratory results among others.

With my permission, the offices of ***Divine Therapy & Wellness*** may mail to my home, or other designated location, any items that assist The Practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. I have the right to request that The Practice restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, though if it does so, is bound by this agreement.

By signing this form, I am allowing ***Divine Therapy & Wellness LLC***. to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

I may make the following special request for confidential communications:

_____
_____
_____
_____

_____ _____/_____/_____
Signature of Patient or Legal Guardian Date

_____
Print Patient's name

_____ _____/_____/_____
Print Legal Guardian's name Date