



**PHYSICAL THERAPY AND
SPORTS MEDICINE CENTER**

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Patient Acknowledgement of Privacy Practices

I have read and fully understand the Physical Therapy and Sports Medicine Center's ("PT&SMC") **Notice of Privacy Practices**. I understand that PT&SMC may use or disclose my protected health information (PHI) for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to request restrictions on how my protected health information is used or disclosed for treatment, payment, and administrative operations if I submit a written request to PT&SMC. I also understand that PT&SMC will consider requests for restriction on a case-by-case basis, but that it is not required to agree to all such requests for restrictions.

I hereby acknowledge the use and disclosure of my protected health information for purposes as described in PT&SMC's **Notice of Privacy Practices**.

Patient Name (please print): _____

Patient Signature: _____ Date: _____