State of Franklin
HEALTHCARE ASSOCIATES
Your Health, Our Focus

PHYSICAL THERAPY
Notice of Privacy Practices
Acknowledgement

I have been given the opportunity to review the Notice of Privacy Practices and understand that the Notice describes how my protected medical information may be used and disclosed and how I may get access to this information. I have also been given the opportunity to take a copy of the Notice of Privacy Practices for further review. I understand that State of Franklin Health Associates has the right to change its Notice of Privacy Practices from time to time and that I may contact State of Franklin Healthcare Associates at any time to obtain a current copy of the Notice of Privacy Practices.

If for some reason the facility needs to relay my protected medical information, i.e. lab results or billing issues, you can either leave or discuss the information with the following individual(s):

Name	Relationship
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

By signing below, I agree to the fore mentioned statements.

Patient Name: ______________________________ Phone: ______________

Patient Signature: ___________________________ Date: _______________

Legal Representative: ________________________ Relationship: __________