CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION AND RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

I, ___________________________________, hereby give my consent to Benchmark Physical Therapy and Wellness Center, LLC, to use or disclose, for the purpose of carrying out treatment, payment or health care operations, all information contained in the patient record of ______________________________.

I acknowledge receipt of the therapist's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the therapist has reserved a right to change his privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available to me upon future visits to the office.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so to the therapist. I also understand that I will not be able to revoke this consent in cases where the therapist has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the therapist's office.

Signed: ___________________________________ Date: ____________________

If you are not the patient, please specify your relationship to the patient.

____________________________________.