Beyond Rehab Health Center

3100 East Charleston Blvd., Suite 107
Las Vegas, NV. 89104

HEALTHCARE AUTHORIZATION FORM (HIPAA)

THE FOLLOWING AUTHORIZES *BEYOND REHAB HEALTH CENTER, PLLC* TO USE AND/OR DISCLOSE PROTECTED HEALTHCARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to *BEYOND REHAB HEALTH CENTER, PLLC* to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related emails messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings.

I give permission to *BEYOND REHAB HEALTH CENTER, PLLC* to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a doctor or assistant in private, the doctor or assistant will provide a private room for these conversations BY APPOINTMENT ONLY.

By signing the following you are giving *BEYOND REHAB HEALTH CENTER, PLLC* permission to use and disclose your protected health information in accordance with the directives listed above.

Signature of Patient/or Legal Guardian:

_____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures; I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health care information for directory purposes.
- The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations.

Signature of Patient/or Legal Guardian:

_____ Date: _____