PRIVACY PRACTICES
WYNDMOOR REHABILITATION ASSOCIATES, P.C. ("WRA")
dba THE CENTER FOR OPTIMAL HEALTH
and
WYNDMOOR PHYSICAL MEDICINE GROUP, P.C. ("WPMG")

Patient Name: _____ Date of Birth: _____ Date Completed: _____

Name of Personal Representative, if applicable: _____

PART A: ACKNOWLEDGMENT OF RECEIPT OF NOTICE. [] Yes [] No
I hereby acknowledge that I have received a copy of Notice of Privacy Practices of WRA and WPMG.

Patient or Personal Representative Signature: _____

PART B: AUTHORIZATION FOR RELEASE OF INFORMATION [] Yes [] No
I hereby authorize the use or disclosure, as appropriate, of my individually identifiable health information by WRA and/or WPMG as described below:
Authorization requested by: patient or representative.
Person/Organization (with address) to receive the information:
_____
What information: _____
Purpose of the use or disclosure: _____

PART C: AUTHORIZATION FOR FOR NOTICES ABOUT OUR PROGRAMS [] Yes [] No
I hereby authorize the use of my **address and/or email** by WRA and/or WPMG as described below.
Authorization requested by: patient or representative.
Person/Organization to receive the information: **WRA and/or WMPG will use your address and/or email only to send you information about our programs but will not release it to other marketing firms. For legal purposes, this is still called "marketing".**
Specific description of information to be released (including date(s) if applicable: **Name, address, email, telephone numbers--no other health information will be used; it will only be used by us and not released to any other agency.**
Purpose of the use or disclosure: **to inform you of future programs and services offered by WRA and/or WPMG**
Section B: If the use or disclosure is for marketing purposes: WRA and/or WPMG **will not** be receiving financial or in-kind compensation in exchange for using or disclosing the information described above.

Complete for all authorizations.
The patient or the patient's representative must read and initial each of the following statements:
_____ I understand that this Authorization is voluntary, and my treatment is not conditioned on my signing this Authorization (unless it relates to my receiving treatment for research purposes as explained above).
_____ I understand that if the entity listed to receive this information is not a health plan or healthcare provider, the information released may no longer be protected by federal privacy regulations.
_____ I understand that the Authorization may be revoked by me in writing, as explained in WRA and/or WPMG's Notice of Privacy Practices, but the revocation won't have any effect on uses or disclosures prior to the revocation.
_____ I understand that the Authorization will expire on __ __/__ __/__ __ (leave blank if you do not want an expiration date).
_____ I understand that I will can receive a copy of this Authorization upon request. Notice is available online as well.
_____ Date: _____
Signature of Patient or Patient's Representative(s) (Both Parents if Patient is a minor)**
Printed Name of Representative(s):_____

_____ Date: _____
Signature of Patient or Patient's Representative**

**** Form MUST be completed prior to signing. You may refuse to sign this Authorization****