SW PHYSICAL THERAPY

503-597-1151
SWPHYSICALTHERAPY.COM
11910 SW GREENBURG RD.
TIGARD, OR 97223

Terms and Conditions/E-mail Consent

Consent for Release of Information: I authorize SW Physical Therapy to use and disclose my health information in order to make decisions about and plan for my care and treatment: refer to consult with , coordinate among and manage along with other health care providers; determine my eligibility for health plan or insurance coverage and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care: and perform various office, administrative , and business functions that support my doctor's efforts to provide, arrange and be reimbursed for my care.

I understand the consent that health information received or created in the course of the delivery of health care at SW Physical Therapy will be used in accordance with SW Physical Therapy Notice of Privacy Practices, which is posted in the lobby area; a copy of the NPP (notice of privacy practice) is available upon request for my review.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the matter described in the NPP, and I understand that SW Physical Therapy is not required by law to agree to such requests.

In compliance with the HIPAA omnibus final rule released January 2013 this consent form expresses that information contained in email messages may be privileged and confidential. There is some risk that any protected health information (PHI) that may be contained in such email may be disclosed to, or intercepted by, unauthorized third parties. Please be aware that email communication can be intercepted in transmission or misdirected. Your use of email to communicate protected health information to me indicates that you acknowledge and accept the possible risks associated with such communication. I Colbie Jorgensen of SW Physical Therapy will respond to your email query, but to do so via email, you must provide your consent, recognizing that email is not a secure form of communication. I will use the minimum necessary amount of protected health information, (PHI), to respond to your query. Please consider communicating any sensitive information by secure portal, telephone, fax, mail or in person at an appointment. If you do not wish to have your information sent by email even after signing this consent form, please fax (503-624-0118), mail, call me (503-597-1255) or make an appointment for an office visit so I can formally document your decision and discontinue email communication. If you wish to conduct discussions regarding your medical issues via email, please indicate your acceptance of this risk by signing below.

Patient/Guardian signature: _____
Date: _____

Printed name: _____
E-mail: _____