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

CLEAR FORM

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

Name of Personal Representative, if applicable: _____ Relationship: _____

Please complete by hand or electronically.

PART A: ACKNOWLEDGMENT OF REVIEW OF NOTICE. ☐**Yes** ☐**No** **Click here to see the Notice.**
I hereby acknowledge that I have reviewed and can print the Notice of Privacy Practices of WRA and WPMG.

Patient or Personal Representative Signature: _____

Complete this section only if you want us to share information with other people involved in your care (parent, partner, etc.

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: ☐all medical records OR ☒ (specify:)_____

Purpose: ☒ continuity of care OR ☐ (specify:)_____

Complete this section if you want us to notify you about our programs and services. Your information will not be shared with any outside agency.

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.**
Purpose of the use or disclosure: **to inform you of future programs and services offered by WRA and/or WPMG**
WRA and/or WPMG **will not** be receiving financial or in-kind compensation in exchange for using or disclosing the information described above.

Complete this section only if you have completed Part B or C.

Complete for Part B and Part C 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) if applicable:_____
**** Form MUST be completed prior to signing. You may refuse to sign this Authorization****