The Gait Center

LAWRENCE REHABILITATION

Privacy and Authorization Form

Print Patient Name: _____ Date of Birth: _____

Our **Notice of Privacy Practices** provides information about how we may use and disclose Protected Healthcare Information (PHI) about you to your insurance company, healthcare providers and whomever you authorize below. As provided in our notice, the terms of our notice may change. If so, the new notice will be in our office, on our website, and available upon request.

The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them. Please provide your telephone number(s) and whether a message regarding your healthcare or billing may be left at that number.

Home Phone: _____ Message: ☐ Yes ☐ No

Cell Phone: _____ Message: ☐ Yes ☐ No

Work Phone: _____ Message: ☐ Yes ☐ No

Medical and billing information may also be disclosed to the following individuals:

Name	Relationship	Phone

Telehealth Visits:
I understand that telehealth is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider.

If I request or initiate a telehealth visit (a "virtual visit") I hereby consent to The Gait Center providing healthcare services to me via telehealth. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth. I understand that my insurance carrier will have access to my medical records for quality review/audit. I understand that I will be responsible for any deductible, copay, and/or co-insurances that apply to my telehealth visit. I understand that I may terminate such visits at any time, without affecting my right to future care or treatment.

We would very much like to keep you aware and informed of the good work being done through our foundation, **Mission Gait**; including the latest patient resources, research, activities, events and campaigns. If you would rather not receive this additional patient information, you will have the opportunity to opt out of the emails by unsubscribing or contacting our office at 804-523-2653.

I acknowledge that the above information has been reviewed and understood. I acknowledge that I have seen the "Notice of Privacy Practices," and understand that I may ask questions about the "Notice of Privacy Practices" at any time. I understand that The Gait Center's Privacy Notice is available via their website at www.lawrencerehabilitation.com/images/Notice_of_Privacy_Practices.pdf. This form applies and extends to subsequent visits and appointments with The Gait Center's providers.

Patient/Parent/Guardian Signature: _____ **Date:** _____/_____/_____