

Rehabilitation Medicine Associates, PC
Physical Medicine and Rehabilitation Specialists
1040 NW 22nd Avenue, Suite 320 • Portland, OR 97210
503.413.6294

ACKNOWLEDGEMENT AND CONSENT

I understand that **Rehabilitation Medicine Associates, PC** (referred to below as “RMA” or “This Practice”) will disclose **health information** about me.

I understand my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that RMA may **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 for my care and treatment;
- 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 of all of my health care; and
- Perform various office, administrative and business functions that support my physician’s efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how RMA will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of RMA, and my rights regarding my health information.

I understand the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy of the most current version of This Practice’s Notice of Privacy Practices in effect will be posted in the waiting/reception area.

I understand I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notices of Privacy Practices, and I understand RMA is not required by law to agree to such requests.

I understand by signing this form I am assigning insurance benefits to be paid directly to Rehabilitation Medicine Associates.

By signing below, I agree that I have reviewed and understand the information above and that I have received or been offered a copy of the Notice of Privacy Practices.

By: _____	Date _____
(Patient)	

-or-

By: _____	Date _____
(Patient representative)	
Description of representatives authority: _____	