

Date ____ / ____ / ____



PELVIC HEALTH

Patient name _____

Acknowledgement of HIPAA

I acknowledge that I received, or was offered, information on HIPAA policy

I authorize **3 Dimensional Physical Therapy Pelvic Health** to discuss my Physical Therapy care with the following individuals (place line through empty lines)

Signature _____ Date ____ / ____ / ____
(Patient)

Signature _____ Date ____ / ____ / ____
(Parent/guardian if patient is a minor)