

Central Mass Physical Therapy & Wellness

Acknowledgement of Privacy Practices

I have received read and understood the notice of privacy practices which has provided a complete description of the uses and disclosures of my health information as outlined by the Health Insurance Portability and Accountability Act of 1996. I understand that I have certain rights regarding my protected health information and that this information can and will be used for purposes of treatment, payment and normal healthcare operations.

Patient name : _____

Signature : _____

Date: _____

Witness : _____

Date: _____