

**Consent to Treatment**

I attest that the medical history information provided is correct to the best of my knowledge. I also hereby give my consent to receive physical therapy services from Mountain View Therapy Services, LLC.

Please initial: \_\_\_\_\_

**Authorization to Release Medical Information**

I hereby authorize the release of my medical and billing records to any healthcare provider involved in my care and treatment. Mountain View Therapy Services, LLC may also release information to any person or organization liable for all or part of my charges, such as my insurance carrier, my adjuster, my insurance claim department, any 3rd party payer, Medicare/Medicaid, my employer’s worker’s compensation carrier, and/or my attorney. I acknowledge that upon the disclosure of medical record information to an insurance company or payer pursuant to this authorization, Mountain View Therapy Services, LLC is no longer responsible for the confidentiality of any information known or possessed by the payer.

Please initial: \_\_\_\_\_

**HIPAA**

I have been offered/provided a copy of the HIPAA policy to review. I have read and understand my rights under HIPAA. A personal copy of the HIPAA agreement will be provided for my records upon request.

Please initial: \_\_\_\_\_

**Consent**

I authorize Mountain View Therapy Services, LLC to release medical information to the following individual.

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Name	Relationship to patient

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Signature of Patient or Guardian

Date