GLACIER PEAKS
mobile physical therapy

Notice Of Patient Information Privacy Practices
HIPAA Notice

This notice describes how medical information about you may be used or disclosed and how you can get access to information, please review it carefully.

Glacier Peak Mobile Physical Therapy's Legal Duty
GLACIER PEAKS MOBILE PHYSICAL THERAPY, LLC (hereafter referred to as GPMPT) is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described in this disclosure.

Uses and Disclosures of Health Information
GPMPT may use your health information for treatment, health care operations, internal administrative activities and obtaining payment for services. GPMPT may use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, and/or for emergencies. We also provide information when required by law. In any other situation, GPMPT will obtain your written authorization prior to disclosing your personal health information for any reason.

Patient's individual Rights
As a patient/client of GPMP, you have the right to review or obtain a copy of your personal health information at any time. You may also request, in writing, that we do not use or disclose your personal health information for treatment, payment or other related administrative purposes, except when specifically authorized by you, when required by law or in emergencies.

Concerns and Complaints
If you are concerned that GPMPT may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of you personal health information, you can file a written complaint to the US Department of Health and Human Services or contact us via by phone: **(406)-426-1560**, or by mail: **Glacier Peaks Mobile Physical Therapy, 880 Hodgson Road, Columbia Falls, MT 59912**

AUTHORIZATION of Patient Privacy
I have fully read and understand GPMPT's Notice of Patient Information Privacy Practices. By signing this form I herby authorize the use and disclosure of my personal health information for purposes stated above. I understand that I have the right to revoke the consent by notifying GPMPT in writing at any time.

Patient Name _____ Date _____

Patient Signature _____

Name of Authorized Legal Representative of Patient (If Applicable)

Name (Print) _____

Signature _____ Date _____