PATIENT INFORMATION CONSENT FORM

I have read and fully understand Taylor Rehab Inc.'s Notice of Patient Information Practices. I understand that Taylor Rehab Inc. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Taylor Rehab Inc. will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Taylor Rehab Inc.'s Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____

Patient Name

_____ _____

Signature **Date**

If I choose to have my medical information communicated to individuals other than myself, I must do so by completing and signing the authorization below.

I do hereby authorize Taylor Rehab to release my medical information to the person/persons listed below.

Name_____**Relationship**_____

Name_____**Relationship**_____

Patient/Guardian Signature_____**Date**_____