WEST BILLINGS
Physical Therapy & Sports Medicine

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BILLINGS, MT 59102-6551
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DOUG CHASE, PT, LAT, CSCS DAN SEBASTIAN, PT, MS, CSCS JILL FOLLETT, MPT

NOTICE OF PRIVACY PRACTICES

PATIENT NAME _____

DOB: _____

I hereby acknowledge that I will be provided a copy upon request of West Billings Physical Therapy Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact West Billings Physical Therapy.

_____ _____
Patient Signature **Date**

_____ _____
Signature or Parent/Guardian or Personal Representative **Date**

RELEASE OF RECORDS

I request and authorize West Billings Physical Therapy to release my healthcare information to the following person(s): List additional names on back.

Name: _____

Address/Phone _____

_____

__ **All Healthcare information**

__ **Healthcare information relating to the following condition, treatment or dates**

_____

_____ _____
Patient Signature **Date**

Release will be in effect until revoked by written notice