iMotion Physical Therapy, Inc.

****** CONSENT TO DISCLOSE HEALTH INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS

Patient Name _____

Home Address_____

Home Phone _____ Date of Birth _____

— Acknowledgment of notification of practice notice of privacy practices: By my signature below, I acknowledge that I have read a copy of the Practice's Notice of Privacy Practices

CONSENT TO DISCLOSE MY GENERAL HEALTH INFORMATION

By my signature below, I hereby authorize the Practice to disclose my medical information so that the Practice may treat me, seek payment from third parties for such treatment and generally carry all the Practice's health care operations. I also authorize the Practice to disclose my medical information to insurers and provider outside of the Practice when necesary so that these providers may treat me, seek payment for that treatment, and for the purpose of their health care operations.

Patient Signature Date