Date_____/_____/_____

3 Dimensional Physical Therapy

A Division of IPTA Clinical

Patient name _____

Acknowledgement of HIPAA

I acknowledge that I received, or was offered, information on HIPAA policy

I authorize IPTA Clinical, to discuss my Physical Therapy care with the following individuals (place line through empty lines)

_____

_____

_____

_____

Signature _____ Date_____/_____/_____
(Patient)

Signature _____ Date_____/_____/_____
(Parent/guardian if patient is a minor)