Chiropractic, Physical Therapy & Massage

# HIPAA Privacy Practices–Patient Reception Form

I have received or reviewed the privacy practice notice for Denver Sports Medicine, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially initiated care at this office on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

_____ _____

Patient/Guardian Signature Date

_____

Print Patient Name

## Exception and Records Release

I allow the doctors and staff at Denver Sports Medicine to discuss my treatment and diagnosis with the following doctors, health care professionals, coaches, lawyers, spouses, etc.

| Name | Title |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
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| _____ | _____ |
| _____ | _____ |
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_____ _____

Patient/Guardian Signature Date

_____

Print Patient Name