Patient Information Practices and Privacy Policy

I have read and understand the attached Notice of Patient Information Practices and Policy. I understand that Jill Loftus, MS, OTR/L, LLC 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 information is used and disclosed for treatment, payment, and administrative operations if I notify this office in writing. I also understand that this office will consider requests for restrictions on a case by base basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosures of my personal health information for purposes as noted in this office's Notice of Patient Information Practices and Policy. In doing so I release Jill Loftus, MS, OTR/L, LLC. from any and all legal liability that may arise from the release of such information. I agree that a copy of this authorization may be used in place of the original.

I understand that the use of the words "you," "your," and "my" In reference to the Notice of Patient Information Practices and Policy refers to the privacy of the child that is receiving the treatment and that I as the parent/guardian am signing this statement on behalf of my minor child.

I understand that I retain the right to revoke this consent by notifying this office in write at any time except for the action which has already been taken. It shall be effective only long enough to answer the purpose of which it is given and no further confidential information will be released without the execution of an additional written authorization.

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Patient and Parent/Guardian Printed Name if Patient is under 18 years old.

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Signature of Parent or Guardian Date