Physical Therapy Patient Confidentiality Agreement

Patient Name:

Date of Birth:

Agreement

I understand that all information shared with my physical therapist is confidential and protected by law. I acknowledge that my health information will not be released to any person or organization without my written consent, except as required by law.

By signing this agreement, I confirm that I have read, understood, and agree to the confidentiality policies regarding my physical therapy treatment.

Patient Signature:

Date:

Therapist Name:

Therapist Signature:

Date: