

**-PIONEER-**  
**PHYSICAL THERAPY**  
108 N Township St. #F  
Sedro-Woolley, WA 98284

**SIGNATURE ON FILE**

{According to 42CFR 424.36 and 45 CFR 164.506}

I authorize disclosure of my Protected Health Information for the purposes of treatment, payment or health care operations (TPO). I understand I have the right to review Pioneer Physical Therapy privacy policies and acknowledge they have been offered to me. I understand I can request restrictions and/or revoke consent.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay claims submitted to health insurance including Medicare, if applicable. If "other health information" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approval claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown.

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_