Sports Therapy and Rehabilitation Services
Privacy Act Affirmations

By my signature, I acknowledge that I have received a copy of the Notice of Privacy for Sports Therapy and Rehabilitation Services, also known as STARS. It is my understanding that STARS preserves the privacy of each patient and provides my information according to my directives.

Name: _____ Date: _____

Signature: _____ Date of Birth: ____/____/_____

Representative Signature: _____ Date: _____

Relationship to Patient: ☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

By my signature I authorize the following directives:

I give permission to leave messages on my voicemail, answering machine, or via email about my appointments and treatments.

☐ Yes ☐ No

Daytime Phone: _____ Evening Phone: _____

Email Address: _____

I give permission to provide information about my therapy treatments and appointments to the following individual:

Name: _____ Phone: _____

I authorize the release of information to my physician.

☐ Yes ☐ No

I authorize the release of information to the insurance company and its representatives.

☐ Yes ☐ No

I understand that Texas Law provides, and I agree, that if any healthcare worker is exposed to my blood or other bodily fluid that Sports Therapy and Rehabilitation Services may perform any tests on my blood or other bodily fluid to determine the presence of any communicable diseases including, but not limited to, Hepatitis, Human Immunodeficiency Virus (which is the causative agent of AIDS) and Syphilis. I understand that such testing is necessary to protect those who will be caring for me while I am a patient at STARS. I understand that the results of tests taken under these circumstances do not become a part of my medical record.

☐ Yes ☐ No

Patient/Representative Signature: _____ Date: _____