CONSENT TO SHARE PROTECTED HEALTH INFORMATION (PHI)

Client Name: _____ **Date of Birth:** _____

I, the undersigned client (or authorized representative – parent/guardian), hereby voluntarily consent Bridging Bionics Foundation to use or disclose my protected health information as described below.

1. Description of Information to be Used/Disclosed:
This consent applies to the following specific health information:

- My initial evaluation report and plan of care
- Progress notes and session documentation
- Outcome measures and functional status reports
- Diagnostic images or test results (if applicable)
- Photographs or videos of my condition or treatment (if applicable)

2. Purpose of Disclosure:
I understand that my protected health information could be used by or disclosed by Bridging Bionics' clinicians and/or staff for purposes of providing physical therapy and training services, carrying out treatment, reporting and providing information, and communications with administrators, licensed physical therapists, physical therapist assistants, doctors, and other allied health professionals. I also understand my information may be shared as part of case studies or presentations to enhance professional knowledge and improve client care.

4. Client Privacy Protections:
I understand that while Bridging Bionics Foundation will make every effort to minimize the use of direct identifiers, the recipients of the information (peers, allied health professionals) may not be covered by federal privacy regulations (HIPAA). The organization will instruct all recipients to keep my information confidential.

5. Right to Revoke Consent:
I understand that I have the right to revoke this consent at any time by providing written notice to Bridging Bionics Foundation. The revocation will be effective upon receipt but will not apply to information that has already been used or disclosed in reliance upon this consent.

I understand that I am not required to sign this consent to receive treatment for services. My treatment will not be conditioned on signing this form.

7. Expiration:
This Consent will expire at the end of the given calendar year upon which it is signed.

8. Signature:
I have read and understand the above information. By signing this form, I voluntarily consent to the use and disclosure of my protected health information as stated above.

_____
Authorized Representative Name (Printed)

_____ Date: _____
Signature