EVERGREEN PHYSICAL THERAPY SPECIALISTS, INC.
200 E. DEL MAR BLVD. SUITE 302, PASADENA, CA 91105

PATIENT REGISTRATION FORM

PATIENT'S NAME_____

GUARDIAN (IF MINOR) _____

PATIENT'S ADDRESS_____

CITY/STATE/ZIP_____

HOME PHONE_____CELL PHONE_____

EMAIL ADDRESS_____

SSN#_____CDL#_____

SEX: MALE FEMALE MARITAL STATUS: S M D W

IN CASE OF EMERGENCY_____**PHONE**_____

REFERRING PHYSICIAN_____PHONE_____

DIAGNOSIS_____DATE OF LAST VISIT_____

DATE OF INJURY/ONSET/SURGERY:_____

ACCIDENT: AUTO WORK OTHER DATE OF ACCIDENT:_____

EMPLOYER NAME:_____PHONE_____

EMPLOYER ADDRESS:_____

CITY/STATE/ZIP_____

ADJUSTOR:_____PHONE_____

HAVE YOU HAD PT, OT, SPEECH, CHIRO, ACCUPUNCTURE THIS YEAR? YES NO
HOW MANY VISITS? _____

EVERGREEN
PHYSICAL THERAPY SPECIALISTS

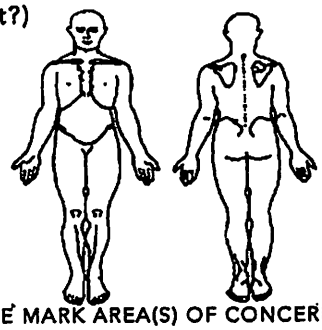
MEDICAL HISTORY

PATIENT NAME: _____ AGE: _____

*HEIGHT: _____ *WEIGHT: _____ ONSET DATE OF INJURY: _____

CONDITION/TYPE OF INJURY OR CAUSE: _____
(Is this due to an auto accident?)

TYPE OF SURGERY & DATE _____



PLEASE MARK AREA(S) OF CONCERN

HAVE YOU HAD ANY IMAGING PERFORMED:

- ☐ X-Ray
- ☐ CT Scan
- ☐ MRI
- ☐ Ultrasound

Date of Imaging: _____

HAVE YOU RECENTLY NOTED:

- ☐ Weight Loss/Gain
- ☐ Weakness
- ☐ Pregnant/IUD
- ☐ Pain at Night
- ☐ Nausea/Vomiting
- ☐ Fever/Chills/Sweats
- ☐ Headaches
- ☐ Leg Cramps when Walking
- ☐ Fatigue
- ☐ Numbness/Tingling
- ☐ Change in Vision/ Hearing
- ☐ Insomnia

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

- ☐ Surgeries
- ☐ Sprains/ Strains
- ☐ Heart Problems
- ☐ Circulation/ Clots
- ☐ Fainting
- ☐ Difficulty Swallowing
- ☐ Loss of Consciousness
- ☐ Diabetes
- ☐ Cancer
- ☐ Asthma/ Breathing Problems
- ☐ Easy Brusing/Bleeding
- ☐ Osteoporosis
- ☐ Fractures
- ☐ Blood Pressure Problems
- ☐ Arthritis
- ☐ Lung Disease
- ☐ Leg/Ankle Swelling
- ☐ Urinary Problems/Infections

Please explain and give approximate dates for any items indicated above: _____

_____

*TYPE OF ALLERGIES (IF ANY) : _____

* LIST OF CURRENT MEDICATIONS	*DOSE	*FREQUENCY
_____	_____	_____
_____	_____	_____

(IF MORE SPACE IS NEEDED, PLEASE LIST ON THE BACK)

*Are you taking VITAMIN D? ☐ YES ☐ NO

*Describe the pain in the last 24 hours: DURING ACTIVITY _____ (SCALE OF 1-10) DURING REST _____ (SCALE OF 1-10)

What makes the pain better or worse? _____

*Have you had 2 or more FALLS within the last 12 months? ☐ YES ☐ NO

*Have you had at least one FALL WITH AN INJURY in the last 12 months? ☐ YES ☐ NO

What are your goals for Physical Therapy? (PLEASE USE BACK OF FORM)

X_____ _____
PATIENT OR AUTHORIZED SIGNATURE DATE

EVERGREEN PHYSICAL THERAPY SPECIALISTS, INC.

PATIENT NAME:_____

_____ *Consent for Care and Treatment*

I, the undersigned, hereby agree and give my consent for above named practice to furnish care and treatment considered necessary and proper in treating my condition.

_____ *Authorization for Signature on File and release of Information*

I, the undersigned, hereby authorize the office of above named practice to affix my name to any and all claim or documents as related to any and all health benefits due me. I authorize the release of any information relating to my health care claims. A photo copy of this authorization shall be as valid as an original.

_____ *Authorization for Assignment of Benefits*

I, the undersigned, hereby assign all medical benefits, to which I am entitled to the office of above named practice, and I shall be financially responsible for any unpaid balance. In the event payment is made directly to me for services rendered by this office, I recognize the obligation to promptly remit payment to this office I hereby authorize and instruct my insurance company to pay directly to the above named practice.

_____ *Financial Responsibility*

I, the undersigned, understand and agree that if it becomes necessary to commence legal action, I am responsible for all costs of collecting moneys owed including court costs, collection agency fees and attorne fees, in addition to my outstanding account balance. I further understand that balances over 60 days will b subject to a 1.5% finance charge, for which I am personally liable.

_____ *Notice of Privacy Practices*

I have read and fully understand the named practice's Notice of Practices. I understand that the above nam practice 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 treatment or payment. I understand that I have the right to restrict how my personal health information i used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that the above named practice will consider requests for restriction on a case by case basis, bu does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my perso health information for purposes as noted in the above named practice's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I have read and fully understand all of the above information and hereby agree to comply outlined above.

Patient or Guardian Signature

Date

EVERGREEN
PHYSICAL THERAPY SPECIALISTS

200 E. Del Mar Blvd. Suite 302, Pasadena, Ca. 91105
Phone: 626-683-8536 Fax: 626-683-8236 Web : Evergreenpt.net

PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT

During the physical therapy evaluation for the problems you have reported, an assessment of your musculoskeletal and neurological problems will be performed. This may include an evaluation of your pelvic floor muscles for strength, resting tone (tightness), and coordination (contract/relax). The findings will be discussed with you, and your physical therapist will develop a treatment plan that is appropriate for you. Your evaluation may include an internal assessment of the pelvic floor muscles, which could be completed vaginally (for females) or rectally (for males or females). Your physical therapist will discuss this option and receive your consent before initiating this exam. You can say "no" at any time. Your physical therapist can assess and treat the pelvic floor muscles externally (from the outside) if needed. The assessment of the pelvic floor muscles may result in soreness or discomfort temporarily. If this occurs, please discuss your symptoms with your physical therapist.

Patients may be apprehensive because of the private nature of the condition and the examination. Please ask as many questions as you need to increase your comfort and understanding of your evaluation, its findings, and treatment. Please discuss any concerns or hesitation that you may have with your physical therapist.

By signing this form, you agree and understand that treatment, as indicated above, may be necessary for effective treatment of your problem, and you are encouraged to notify your physical therapist of any changes to your preferences. You will have the opportunity to give/revoke your consent at each treatment session

If you are pregnant, have an infection of any kind, are less than 6 weeks postpartum or post surgery, have sensitivity to lubricant, please inform the therapist prior to the pelvic floor assessment.

Date: _____

Patient Name: _____ Patient Signature: _____

Witness Name: _____ Witness Signature: _____

PFDI- 20 Instructions: Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder, or pelvic symptoms and, if you do, how much they bother you. Answer these by circling the appropriate number. While answering these questions, please consider your symptoms over the **last 3 months**.

The PFDI-20 has 20 items and 3 scales of your symptoms.
All items use the following format with a response scale from 0 to 4.

Symptoms Present = YES, scale of bother:
1 = not at all
2 = somewhat
3 = moderately
4 = quite a bit

Symptoms Not Present = NO
0 = not present

Pelvic Organ Prolapse Distress Inventory 6 (POPDI-6)

Do you ...	No	Yes
1. Usually experience pressure in the lower abdomen?	0	1 2 3 4
2. Usually experience heaviness or dullness in the pelvic area?	0	1 2 3 4
3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?	0	1 2 3 4
4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	0	1 2 3 4
5. Usually experience a feeling of incomplete bladder emptying?	0	1 2 3 4
6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0	1 2 3 4

Colorectal-Anal Distress Inventory 8 (CRAD-8):

Do you ...	No	Yes
7. Feel you need to strain too hard to have a bowel movement?	0	1 2 3 4
8. Feel you have not completely emptied your bowels at the end of a bowel movement?	0	1 2 3 4
9. Usually lose stool beyond your control if your stool is well formed?	0	1 2 3 4
10. Usually lose stool beyond your control if your stool is loose?	0	1 2 3 4
11. Usually lose gas from the rectum beyond your control?	0	1 2 3 4
12. Usually have pain when you pass your stool?	0	1 2 3 4
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1 2 3 4
14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	0	1 2 3 4

Urinary Distress Inventory 6 (UDI-6):

Do you ...	No	Yes
15. Usually experience frequent urination?	0	1 2 3 4
16. Usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom?	0	1 2 3 4
17. Usually experience urine leakage related to coughing, sneezing, or laughing?	0	1 2 3 4
18. Usually experience small amounts of urine leakage (that is, drops)?	0	1 2 3 4
19. Usually experience difficulty emptying your bladder?	0	1 2 3 4
20. Usually experience *pain* or *discomfort* in the lower abdomen or genital region?	0	1 2 3 4

Scoring the PFDI-20:

Scale Scores: Obtain the mean value of all of the answered items within the corresponding scale (possible value 0 to 4) and then multiply by 25 to obtain the scale score (range 0 to 100). Missing items are dealt with by using the mean from answered items only.

PFSI-20 Summary Score: Add the scores from the 3 scales together to obtain the summary score (range 0 to 300).

PFIQ – 7 Instructions: Some women find that bladder, bowel, or vaginal symptoms affect their activities, relationships, and feelings. For each question place an **X** in the response that best describes how much your activities, relationships, or feelings have been affected by your bladder, bowel, or vaginal symptoms or conditions **over the last 3 months**. Please make sure you mark an answer in all 3 columns for each question.

How do symptoms or conditions relating to the following → → → Usually affect your ...↓	***Bladder or urine***	***Bowel or rectum***	***Vagina or pelvis***
1. Ability to do household chores (cooking, housecleaning, laundry)?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
2. Ability to do physical activities such as walking, swimming, or other exercise?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
3. Entertainment activities such as going to a movie or concert?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
5. Participating in social activities outside your home?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
6. Emotional health (nervousness, depression, etc.)?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
7. Feeling frustrated?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

Pelvic Floor Therapy Questionnaire

Patient name _____ **Date** _____

Please fill in the following questionnaire to the best of your ability. The therapist will review the answers with you at your appointment.

History

Number of pregnancies _____ Number and Date(s) of vaginal deliveries _____

Birth weight of largest baby _____ Number and Date(s) of cesarian deliveries _____

Number of episiotomies _____ Date of last pap smear _____

Did you have any trouble healing after delivery Y N

Do you have a history of sexual abuse or trauma Y N

Are you having regular periods/ menstrual cycles Y N

Do you have frequent urinary tract infections Y N

Pain

Do you have pain with:

Sexual intercourse	Y	N	If Yes, when did you start having pain? _____
Pelvic exam	Y	N	
Tampon use	Y	N	
Back, leg, groin, abdominal pain	Y	N	

Test results

Urodynamics test	Y	N	Results: _____
Cystoscope	Y	N	Results: _____
Urine test	Y	N	Results: _____
Bowel test	Y	N	Results: _____

Bladder symptoms

Do you lose urine when you:

Cough/ sneeze/ laugh	Y	N	Lift/ exercise/ dance/ jump	Y	N
On the way to the bathroom	Y	N	Have a strong urge to urinate	Y	N
Hear running water	Y	N	Other _____	Y	N

Do you wet the bed	Y	N	When did urine leakage start? _____
Have burning/ pain with urination	Y	N	Amount of leakage: A few drops, wets underwear, complete loss of bladder control
Difficulty starting a stream of urine	Y	N	
Strain to empty your bladder	Y	N	
Feel unable to empty bladder fully	Y	N	
Have a falling out feeling	Y	N	
Have pain with a full bladder	Y	N	
Have an urgency of urination (a strong urge to urinate)	Y	N	
Urinate more than 7 times/day	Y	N	

Bowel symptoms

Strain to have a bowel movement	Y	N	Leak / stain feces	Y	N
Include fiber in your diet	Y	N	Have diarrhea often	Y	N
Take laxatives / enema regularly	Y	N	Leak gas by accident	Y	N
Have pain with bowel movement	Y	N			

Have a very strong urge to move your bowels Y N

How often do you move your bowels: _____ per day, week

Most common stool consistency

____ liquid ___ soft ___ firm ___ pellets ___ other _____

Thank you for taking the time to fill out this questionnaire.

Office Use Only: MRN

Patient-Specific Functional Scale

Name: _____ **Date:** _____

Please read the following and complete.

Please identify **up to three important activities** that you are unable to do or are **having difficulty with** as a result of your current problem/diagnosis (i.e. the reason your doctor has referred you to therapy). Today, are there any activities that you are unable to do or having difficulty with because of your problem/diagnosis?

Please rate each of these problems on the 0-10 scale below.

0 = Able to perform activity at the same level as before injury or problem (No issues)

10 = Unable to perform activity (Cannot perform)

Patient-specific activity scoring scheme (Circle one number or provide a range):

1. Activity:										
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
No Issues										**Cannot perform**

2. Activity:										
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
No Issues										**Cannot perform**

3. Activity:										
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
No Issues										**Cannot perform**

NOTICE OF PRIVACY PACTICES

EFFECTIVE APRIL 14, 2004

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATIN ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMAION. PLEASE REVIEW IT CAREFULLY

USES AND DISCLOSES OF YOUR MEDICAL INFORMATION

FOR TREATMENT: WE MAY USE MEDICAL INFORMATION ABOUT YOU TO PROVIDE YOU WITH MEDICAL TREATMENT OR SERVICES.
FOR PAYMENTS: WE MAY USE AND DISCUSS MEDICAL INFORMATION ABOUT YOU SO THAT THE TREATMENT AND SERVICES YOU RECEIVE AT OUR PRACTICE MAY BE BILLED TO AND PAYMENT MAY BE COLLECTED FROM YOU, AN INSURANCE COMPANY, OR A THID PARTY.
FOR HEALTH CARE OPERATIONS: WE MAY USE AND DISCLOSE HEALTH INFORMAION ABOUT YOU FOR OPERATIONS OF OUR HEALTH CARE PRACTICE.
FOR INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE: WE MAY RELEASE MEDICAL INFORMATION ABOUT YOU TO A FRIEND OR FAMILY MEMBER WHO IS INVOLVED IN YOUR MEDICAL CARE.
FOR HEALTH RELATED SERVICES AND TREATMENT ALTERNATIVES: WE MAY USE AND DISCLOSE HEALTH INFORMATION TO TELL YOU ABOUT HEALTHER-RELATED SERVICES OR RECOMMEND POSSIBLE TREATMENT OPTIONS OR ALTERNATIVES THAT MAY BE OF INTEREST TO YOU.
AS REQUIRED BY LAW: WE WILL DISCUSS MEDICAL INFORMATION ABOUT YOU WHEN REQUIRED TO DO SO BY FEDERAL, STATE, OR LOCAL LAW.
TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY: WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU WHEN NECESSARY TO PREVENT A SERIOUS THREAT TO YOUR HEALTH AND SAFETY OR THE HEALTH AND SAFETY OF THE PUBLIC OR ANOTHER PERSON.
FOR MILITARY AND VETERANS: IF YOU ARE A MEMBER OF THE ARMED FORCES, WE MAY RELEASE MEDICAL INFORMATION ABOUT YOU AS REQUIRED BY MILITARY COMMAND AUTHORITIES.
FOR WORKER'S COMPENSATION: WE MAY RELEASE MEDICAL INFORMATION ABOUT YOU FOR WORKER'S COMPENSATION OR SIMILAR PROGRAMS.
FOR PUBLIC HEALTH RISKS: WE MAY DISCLOSE MEDICAL INFORMATION ABOUT YOU FOR PUBLIC HEALTH ACTIVITIES.
FOR HEALTH OVERSIGHT ACTIVITIES: WE MAY DISCLOSE MEDICAL INFORMATION TO A HEALTH OVERSIGHT AGENCY FOR ACTIVITIES AUTHORIZED BY LAW.
FOR LAWSUITS AND DISPUTES: IF YOU ARE INVOLVED IN A LAWSUIT OR A DISPUTE, WE MAY DISCLOSE MEDICAL INFORMATION ABOUT YOU IN RESPONSE TO A COURT OR ADMINISTRATIVE ORDER.
FOR LAW ENFORCEMENT: WE MAY RELEASE MEDICAL INFORMATION IF ASKED TO DO SO BY LAW ENFORCEMENT OFFICIALS.
FOR CORONERS, MEDICAL EXAMINERS, AND FUNERAL DIRECTOS: WE MAY RELEASE MEDICAL INFORMATION TO A CORONER OR MEDICAL EXAMINER.
FOR NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES: WE MAY RELEASE MEDICAL INFORMATION ABOUT YOU TO AUTHORIZED FEDERAL OFFICIALS FOR INTELLIGENCE, COUNTER INTELLIGENCE, AND OTHER NATIONAL SECURITY ACTIVITIES AUTHORIZED BY LAW.
FOR PROTECTIVE SERVICES FOR THE PRESIDENT AND OTHERS: WE MAY DISCLOSE MEDICAL INFORATION ABOUT YOU TO AUTHORIZED FEDERAL OFFICALS SO THEY MAY PROVIDE PROTECTIOON TO THE PRESIDENT, OTHER AUTHERIZED PERSONS OR FOREIGN HEADS OF STATE OR CONDUCT SPECIAL INVESTIGATIONS.
FOR INMATES: IF YOU ARE AN INMATE OF A CORRECTIONAL INSTITUTION OR UNDER THE CUSTODY OF LAW ENFORCEMENT OFFICAL, WE MAY RELEASE MEDICAL INFORMATION ABOUT YOU TO THE CORRECTIONAL INSTITUTION OR LAW ENFORMENT OFFICAL.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

YOUR RIGHT TO INSPECT AND COPY: TO INSPECT AND COPY OF OUR MEDICAL INFORMATION, YOU MUST SUBMIT YOUR REQUEST IN WRITING. WE MAY DENY YOUR REQUEST TO INSPECT AND COPY, IN LIMITED CIRCUMSTANCES. IF YOU ARE DENIED ACCESS TO MEDICAL INFORMATION, YOU MAY REQUEST IN WRITING, THAT THE DENIAL BE REVIEWED.
YOUR RIGHT TO AMEND: IF YOU FEEL THAT MEDICAL INFORMATION WE HAVE ABOUT YOU IS INCORRECT OR INCOMPLETE, YOU MAY REQUEST AN AMENDMENT IN WRITING. YOUR REQUEST MAY BE DENIED IF YOU DO NOT INCLUDE A REASON TO SUPPORT THE REQUEST.
YOUR RIGHT TO AN ACCOUNTING OF DISCLOSURES: YOU HAVE THE RIGHT TO REQUEST IN WRITING, A LIST ACCOUNTING FOR MY DISCLOSURES OF YOUR MEDICAL INFORMATION WE HAVE MADE, EXCEPT FOR USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, AS PREVIOUSLEY DESCRIBED.
YOUR RIGHT TO REQUEST RESTRICTIONS: YOU HAVE THE RIGHT TO REQUEST A RESTRICTION OR LIMITATION ON THE MEDICAL INFORMATION WE USE OR DISCLOSE ABOUT YOUR FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. *We are not required to agree to your request.*
YOUR RIGHT TO REQUEST CONFIDENTAIL COMMUNICATION: YOU HAVE THE RIGHT TO REQUEST IN WRITING THAT WE COMMUNICATE WITH YOU ABOUT MEDICAL MATTERS IN A CERTAIN WAY OR AT A CERTAIN LOCATION.
YOUR RIGHT TO A PAPER COPY OF THIS NOTICE: YOU HAVE THE RIGHT TO A PAPER COPY OF THIS NOTICE AT ANY TIME.
CHANGES TO THIS NOTICE: WE RESERVE THE RIGH TO CHANGE THIS NOTICE, AND WILL POST THE CURRENT NOTICE IN OUR FACILITY.
COMPLAINTS: IF YOU BELIEVE YOUR PRIVACY RIGHT HAVE BEEN VIOLATED, YOU MAY FILE A COMPLAINT WITH THE PRACTIVE OR WITH THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.
OTHER USES OF MEDICAL INFORMATION: OTHER USES AND DISCLOSURES OF MEDICAL INFORMATION NOT COVERED BY THIS NOTICE OR THE LAWS THAT APPLY TO US WILL BE MADE ONLY WITH YOUR WRITTEN PERMISSION. IF YOU PROVIDE US PERMISSION TO USE OR DISCLOSE MEDICAL INFORMATION ABOUT YOU, YOU MAY RECEIVE THAT PERMISSION, IN WRITING, AT ANY TIME. IF YOU REVOKE YOUR PERMISSION, WE WILL NO LONGER USE OR DISCLOSE MEDICAL INFORMATION ABOUT YOU FOR THE REASONS COVERED BY YOUR WRITTEN AUTHORIZATION. YOU UNDERSTAND THAT WE ARE UNABLE TO TAKE BACK ANY DISCLOSURES WE HAVE ALREADY MADE WITH YOUR PERMISSION, AND THAT WE ARE REQUIRED TO RETAIN OUR RECORDS OF THE CARE THAT WE PROVIDED TO YOU.