Patient Consent for the Use and Disclosure of Protected Health Information

This is my consent for (*Practice Name*) to use and disclose my protected health information to carry out treatment, payment, and healthcare operations. This is my acknowledgement that I may view (Practice Name)'s Notice of Privacy Practices.

This is my consent for (*Practice Name*) to:

_____ Call my home and leave a message on voicemail or in person to remind me of appointments, or obtain insurance information.

_____ Call and leave reports of my clinical care; lab results.

_____ E-mail me using my personal or other designated email address with appointment reminders and other matters related to my clinical care.

_____ Mail items that assist in carrying out my treatment, payment, or health operations, such as appointment reminder cards and patient statements to:

- ☐ my home
- ☐ other designated location: _____

_____

This is my consent for information regarding my general health and treatment to be discussed with the following people:

_____

_____

This is my consent for information regarding my health and treatment to be discussed with the following people in the event of an emergency:

_____

_____

By signing this form, I am consenting to (*Practice Name*)'s use and disclosure of my protected health information to carry out treatment, payment, and healthcare operations. I may revoke my consent in writing except on those disclosures made prior to my consent. I understand that (*Practice Name*) reserves the right to refuse to treat me if I do not sign this consent form.

_____ _____

Patient's Name Date

_____

Signature of Patient or Legal Guardian

_____

Print Name of Patient or Legal Guardian