PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Dr._____ or employees may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dr. _____ 's Notice of privacy practice for a more complete description of such uses and disclosures.

I have the right to review the Notice of privacy Practices prior to signing this consent. Dr._____ reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to _____, Privacy Officer at _____(physician address).

With my consent, Dr._____ may call my home or other designated location and leave a message on a voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Dr._____ may mail to my home, or other designated locations, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Dr._____ or employees' use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. IF I DO NOT SIGN THIS CONSENT, DR._____ MAY DECLINE TO PROVIDE TREATMENT TO ME.

_____ _____

Signature of Patient or Guardian Date

_____

Patient Name

ADDITIONAL CONSENT

I hereby give my consent to the office of Dr. _____ to release any information concerning any ongoing care to the below listed person(s). Information that may be released shall include verbal communications involving lab reports, procedures, pathology results, office return visits, or any other information deemed necessary in my care.
Said person(s) will be required to give a password or number so that information may be verbally released.

RECIPIENT OF INFORMATION	PASSWORD
_____	_____
_____	_____
_____	_____
Patient Signature	Date