Consent Form

Public Law 104-191 (Health Insurance Portability and Accountability Act of 1996) contains a provision for covered health care providers to obtain a general consent form from the individual in order to use or disclose protected health information (PHI) for treatment, payment and health care operations (TPO). I understand that PHI is used at this facility as:

- A basis for planning my care and treatment.
- A means of communication among the health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I may decide to not provide my consent on this form and I am aware that this facility may condition treatment on my agreement to provide consent. By my signature below, I am providing consent for this facility to share protected health information only for purposes of TPO. I understand consent need only be obtained one time and that future visits will be covered under this consent.

Individual Rights

- I have the right to review and obtain a copy of this facility's Privacy Notice prior to consenting.
- I may revoke my consent in writing. This facility will continue, however, to use the previous consent for all TPO preceding my revocation.
- I may request restrictions on uses or disclosures of health information for TPO. This facility may not agree to the restriction requested but is bound by any restriction to which it does agree.

I understand that my consent permits this facility to undertake the following activities:

- It may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO (i.e., appointment reminders, insurance items, etc.).
- It may mail to my home or designated location items that assist the practice in carrying out TPO, such as appointment reminders, statements, etc.

________________________________________
Patient's Name (Printed)

________________________________________  ________________
Signature (Patient or Guardian)    Date