

PATIENT CONSENT FOR USE & DISCLOSURE OF PROTECTED

HEALTH INFORMATION

I hereby give my consent for Wattles Park Family Practice to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). The Notice of Privacy provided by Wattles Park Family Practice describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Wattles Park Family Practice reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Wattles Park Family Practice, Attn: Privacy Officer, at the above address.

With this consent, Wattles Park Family Practice may call, mail, or e-mail to my home or other alternative location and leave a message on voice mail, with a responsible party who answers the phone or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care.

By signing this form, I am consenting to allow Wattles Park Family Practice to use and disclose 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, or later revoke it, Wattles Park Family Practice may decline to provide treatment to me.

Signature of Patient/legal guardian Date Relationship to patient

Print Name of Patient Print Name of Legal Guardian if Applicable

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