Optimum Health Family Practice

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## PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact Optimum Health Family Practice at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

## PERMISSION TO DISCLOSE INFORMATION

**I hereby allow Optimum Health Family Practice disclose the following Protected Health Information:**

- ☐ Appointment Dates
- ☐ Tests that have been received
- ☐ Test results
- ☐ Other health information

**With whom may we discuss your medical information?**

Individual Name ______________________ Relationship ______________

Individual Name ______________________ Relationship ______________

Individual Name ______________________ Relationship ______________

Individual Name ______________________ Relationship ______________

**You have permission to contact me in the following forms of communication:**

| | | | |
|---|---|---|---|
| _____ Home Phone | ______________ | May we leave a Voicemail? | YES or NO |
| _____ Work Phone | ______________ | May we leave a Voicemail? | YES or NO |
| _____ Cell Phone | ______________ | May we leave a Voicemail? | YES or NO |
| _____ Other/Email | ______________ | May we send an Email? | YES or NO |

Patient Name (print & signature) ______________________________

Date of Birth ______________ Date ______________