

Safecare Medical Center
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name _____ **Date of Birth** _____

Address _____ **Telephone** _____

To the Patient – Please read the following statements carefully.

Purpose of Consent. By signing this form, you will consent to our use and disclosure of your protected health information with other healthcare providers and insurance companies to carry out treatment, payment activities and healthcare operations (including paper, oral and electronic interchange).

Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information to carry out treatment, payment activities and healthcare operations. We encourage you to read our Notice of Privacy Practices carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices at any time. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our Protected Health Information (PHI) that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office.

Right to Revoke. You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to our office. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility or benefits.

Acknowledgement of receipt of Privacy Practices and consent to disclose: I have had full opportunity to read and consider the contents of this consent-form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my Protected Health Information (PHI) to carry out treatment, payment activities and healthcare operations.

I, _____, have received a copy of this office's Notice of Privacy Practices and provide consent for the disclosure of PHI as outlined in this document.

Signature _____ **Date** _____

I also authorize my Healthcare provider to discuss or release my Protected Health Information (PHI) to:

_____, _____
(Name/Relationship) (Name/Relationship)

Signature _____ **Date** _____

For Office Use Only. Acknowledgement of receipt of our Notice of Privacy Practices could not be obtained because:

- ____ Individual refused to sign
- ____ Communication barriers prohibited obtaining signature
- ____ An Emergency situation prevented us from obtaining signature
- ____ Other _____