

Scottsdale Family Health

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Scottsdale Family Health may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations. (TPO), Please refer to Scottsdale Family Health’s notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing the consent. Scottsdale Family Health 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 Scottsdale Family Health’s Privacy Officer at 3501 N. Scottsdale Road, Suite 334, Scottsdale, AZ 85251.

With my consent, Scottsdale Family Health 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, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

_____ (Initials)

With my consent, Scottsdale Family Health may mail/e-mail to my home or other designated location 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. I have the right to request that Scottsdale Family Health restrict how it uses or discloses my PHI to carry out TPO. _____ (Initials)

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 Scottsdale Family Health’s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Scottsdale Family Health may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patients Name

Date

Print Name of Patient or Legal Guardian

Witness

Date