Patient Consent For Use and Disclosure of PHI

I, the undersigned, give my consent to the provider, it's agents and assigns to: (i) use or disclose my protected health information ("PHI") to carry out treatment, payment, or health care operations; (ii) release my entire medical record to any other provider or its employees upon a representation that the provider will use the information for treatment or payment; (iii) disclose billing information to any person that calls the provider with billing questions after the provider inquires as to the identity of the calling person and the calling person provides my correct social security number or health plan number; (iv) call and leave a voice mail message at my home or other number that I provide them regarding medical appointments, billing or payment issues, or other information related to treatment, payment or health care operations; (v) discuss my PHI with: (a) any person that accompanies me to a visit or procedure or is present with me when the provider is present, and (b) any person that identifies himself or herself as active in my mental, physical, emotional or spiritual care, including but not limited to family, close personal friends, clergy and patient advocates.

Assignment of Benefits: I hereby authorize any insurance benefits be paid directly to the physical and I understand that I am responsible for non-covered services. I also authorize the treating provider to release any information required in the processing of the claim. I also assign my rights to bring claims for lack of payment, to the below named healthcare provider(s).

If you understand and accept the foregoing, please sign on the line provided below:

Signed: ______________________________ Date: ______________

Print Name: ____

Name of Minor Child (if applicable): ______________________________

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