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**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION and ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

With my consent, Heights Medical may use and disclose protected health information (PHI) about me to carry out treatment, payment of healthcare operations (TPO). Refer to Heights Medical’s Notice of Privacy Practices (NPP) for a more complete description of such uses and disclosures.

I have the right to review the NPP prior to signing this consent. Heights Medical reserves the right to review its NPP at any time. NPP may be obtained at any time on line at the Heights Medical website or by requesting at the office.

With my consent, Heights Medical may mail, e-mail or call my home or other designated location and leave a message on voice mail or in person in reference to items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including lab results.

I have the right to request that Heights Medical restricts how it uses or discloses my PHI to carry out TPO. 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 Heights Medical’s use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign the consent, Heights Medical may decline to provide treatment to me.

Document PR1-B

**Acknowledgement of Receipt – Notice of Privacy Practices\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I acknowledge that I have been provided the Notice of Privacy Practices (NPP) of Heights Medical Associates. The NPP tells me how Heights Medical Associates may use or disclose my Protected Health Information (PHI) and about my rights and the legal duties of Heights Medical Associates regarding my PHI.

I understand that if I have any questions the NPP provides me with the name or title and telephone number of a person or office to contact for further information.

**Date: \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Individual Name: Print\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Sign**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Social Security #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Identity of the Individual verified, Documentation on file.**

Heights Medical Employee Initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Individual or Personal Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Personal Representative, if any \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Representative Authority to Act for the Individual \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Documentation may be requested)

Identity and Authority to Act of Personal Representative verified, Documentation on file confirmed by Representative.

Signature Printed Name

Or

Made a good faith effort to obtain a written acknowledgment of the NPP but was unable to because:

Representative:

Signature Printed Name