CREEKSIDE MEDICAL, PS

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Creekside Medical, PS** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **Creekside Medical, PS** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Creekside Medical, PS** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Michelle Vincent, 900 NE 139th St, #202, Vancouver, WA 98685.

With this consent, **Creekside Medical, PS** may call my home or other alternative number 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 calls pertaining to my clinical care, including laboratory test results, among others.

Cell Phone # ____________________________ () 1st choice () 2nd choice / () Text () Voicemail

Home Phone #___________________________ () 1st choice () 2nd choice / () Voicemail

With this consent **Creekside Medical, PS** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I hereby authorize Creekside Medical, PS to release PHI to the person(s) listed below:

____ ______________________
Name Relationship

____ ______________________
Name Relationship

____ ______________________
Name Relationship

I have the right to request that **Creekside Medical, PS** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

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By signing this form, I am consenting to allow **Creekside Medical, PS** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Creekside Medical, PS** may decline to provide treatment to me.

______________________________ ______________________
Signature of Patient or Legal Guardian Date of Birth

______________________________ ______________________
Print Patient's Name Date

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Print Name of Patient or Legal Guardian, if applicable
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