Patient Consent for Use and Disclosure of Protected Health Information

Today's Date: __________ Patient Name: ________________________________ Date of Birth: __________
Last First Middle or Maiden

Address: ______________________ City: ______________ State: ______ Zip: __________

Soc. Sec. No.: ______________________ Telephone: ______________________

Use of this form is optional and not required under the HIPAA privacy rule.

I hereby give my consent for River Hills Family Medicine 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 River Hills Family Medicine describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. River Hills Family Medicine 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, Office Manager, River Hills Family Medicine, 7011 Ribelin Ranch Drive Suite 200, Austin, TX 78750.

With this consent, River Hills Family Medicine may call my home or other alternative 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 calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, River Hills Family Medicine 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 as long as they are marked "Personal and Confidential."

With this consent, River Hills Family Medicine may e-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 have the right to request that River Hills Family Medicine 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.

By signing this form, I am consenting to allow River Hills Family Medicine 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, River Hills Family Medicine may decline to provide treatment to me.

Patient Signature: ________________________________ Date: __________

Parent or Legal Guardian Signature: ________________________________

______________________________ ______________________________
Name Relationship

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Please return completed form to the appropriate physician's office.

CONFIDENTIAL