Effective Date of this Notice: 4/14/2003

Patient Consent for the Use and Disclosure of Protected Health Information

This is my consent for **SPORTSMED ORTHOPAEDIC SPECIALISTS, P.C.** to use and disclose my protected health information to carry out treatment, payment, and healthcare operations. This is my acknowledgement that I may view **SPORTSMED ORTHOPAEDIC SPECIALISTS, P.C.** Notice of Privacy Practices.

This is my consent for **SPORTSMED ORTHOPAEDIC SPECIALISTS, P.C.** to

_____ Call my home and leave a message on voicemail or in person to remind me of appointments, or obtain insurance information. We have an automated service that will call and remind you of your appointment date and time.

_____ Call and leave reports of my clinical care; lab results.

_____ E-mail me using my personal or other designated email address with appointment reminders and other matters related to my clinical care.

_____ Mail items that assist in carrying out my treatment, payment, or health questions, such as appointment reminder cards and patient statements to:

- ❑ my home
- ❑ other designated location: _____

_____

This is my consent for information regarding my general health and treatment to be discussed with the following people please print their name and telephone number:

_____

_____

This is my consent for information regarding my health and treatment to be discussed with the following people in the event of an emergency please print their name and telephone contact number:

_____

_____

By signing this form, I am consenting to **SPORTSMED ORTHOPAEDIC SPECIALISTS, P.C.** use and disclosure of my protected health information to carry out treatment, payment, and healthcare operations. I may revoke my consent in writing except on those disclosures made prior to my consent. I understand that **SPORTSMED ORTHOPAEDIC SPECIALISTS, P.C.** reserves the right to refuse to treat me if I do not sign this consent form.

_____ _____

Patient's Name Please Print Date

_____

Signature of Patient or Legal Guardian