



Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Belt Line Medical 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 Belt Line Medical describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Belt Line Medical Clinic 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 Dr. Harman Kaur, 4321 N Beltline Rd #500, Mesquite, TX 75150.

With this consent, Belt Line Medical Clinic 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, Belt Line Medical Clinic 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, Belt Line Medical Clinic 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 Belt Line Medical Clinic 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 Belt Line Medical Clinic 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, Belt Line Medical Clinic may decline to provide treatment to me.

Email address

Cell Phone for Text Messages

Preferred Method of Communication

Next of Kin, Phone & Address

Signature of Patient or Legal Guardian

Print Patient's Name

Date

Print Name of Patient or Legal Guardian, if applicable

Note: This document is a template only. It does not reflect the requirements of your state's laws. You should consult with advisors (your state or local medical or specialty society, or legal or other counsel) familiar with your state's privacy laws prior to using this document.

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