West Bend Family Medicine

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for West Bend Family Medicine (Practice) to use and disclose protected health information about me to carry out Treatment, Payment and health care Operations (TPO).

I have the right to review the Notice of Privacy Practices of West Bend Family Medicine prior to signing this consent. West Bend 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 sending a written request to West Bend Family Medicine, attention Medical Records.

I am entitled, by written request, to obtain a copy of my medical records.

Cell or Telephone: With this consent, West Bend Family Medicine may call my home or other alternative phone 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 verification items and any calls pertaining to my clinical care.

Mail: With this consent, West Bend Family Medicine may mail to my home or other alternative locations, any items that assist with the practice of carrying out TPO, such as appointment reminder cards or letters, patient account statements and letters pertaining to my clinical care.

Email: With this consent, West Bend Family Medicine may email to my home or other alternative locations, any items that assist with the practice of carrying out TPO, such as appointment reminder cards or letters, patient account statements and letters or messages pertaining to my clinical care.

I have the right to request that West Bend Family Medicine restrict how it uses or discloses my protected health information 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 West Bend Family Medicine to use and disclose my protected health information 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, West Bend Family Medicine may decline to provide treatment to me.

Print Patient Name: _____

Signature of Patient or Legal Guardian _____

Date_____