PrimeHealth
PRIMARY CARE

Patient Consent for Receipt and Transmittal of Protected Health Information

1. Mail notices to your home address: Yes No

2. Leave the following information on your HOME/ CELL voicemail:
   - Appointment Information Yes No
   - Billing Information Yes No
   - Medical Information Yes No
   - Prescription Refills Yes No
   - Authorizations and/ or Referrals Yes No

3. Leave the following information on your WORK voicemail:
   - Appointment Information Yes No
   - Billing Information Yes No
   - Medical Information Yes No
   - Prescription Refills Yes No
   - Authorizations and/ or Referrals Yes No

4. I give permission to PrimeHealth Urgent Care to share **appointment and billing** information with the following people listed below:

Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

5. I give permission to PrimeHealth Urgent Care to share **medical information** with the following people listed below:

Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

Patient Printed Name: _____ **Date of Birth:** _____

Patient Signature: _____ **Date:** _____

Guardian Signature: _____ **Date:** _____
(if patient is under 18 years old)

(PLEASE TURN PAGE OVER AND CONTINUE ON BACK) →

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I, _____, understand that as part of my healthcare, **PrimeHealth Primary Care** originates and maintains paper and/ or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care □ A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand that **PrimeHealth Primary Care** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization my refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that **PrimeHealth Primary Care** reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should **PrimeHealth Primary Care** change their notice, they will send a copy of any revised notice to the address I have provided (whether US mail or if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax and secure email.

I fully understand and accept/ decline the terms of this consent.

Signature: _____ Date: _____

Patient's signature or authorized representative signing for the patient.