PATIENT CONSENT FORM

Dr. Joshua Crum, MD

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
*Obtain payment from third-party payers.
*Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you and your *Notice of Privacy Practices* containing a more complete description of the used and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notices of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Can we call you at home? ☐ Yes ☐ No

Can we leave a message on your voice mail/answering machine? ☐ Yes ☐ No

Can we call you at work? ☐ Yes ☐ No

Can we leave you a message at work? ☐ Yes ☐ No

I authorize your office to disclose the specific information below, only for the purposes and parties described below. I may revoke this authorization in writing by contacting your office: (Please list the name & phone number of anyone (Spouse, Parent, Child, etc.) you would allow us to share your medical information with. This includes any information regarding treatment, account balance, appointment date and time, etc.)

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Patient Name:_____

Signature: _____ Date:_____