Final CIM Logo

**Patient Consent for Use and Disclosure**

**Of Protected Health Information**

I hereby give my consent for Center For Interventional Medicine 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 Center For Interventional Medicine describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Center For Interventional Medicine reserves the right to revise its Notice of Privacy Practices at any time.

With this consent, Center For Interventional Medicine 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, Center For Interventional Medicine 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.

By signing this form, I am consenting to allow Center For Interventional Medicine to use and disclose my PHI to carry out TPO.

By signing this form, I am consenting to allow Center For Interventional Medicine to use any before and/or after photos for such usage as advertising.

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, Center For Interventional Medicine may decline to provide treatment to me.

I acknowledge that I have been offered or received a copy of the Notice of Privacy Practices as required by the Health Portability and Accountability Act (HIPPA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CRF Parts 160 and 164. This notice Describes show health information about you may be used and disclosed and how you can get access to this information.

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Signature of Patient or Legal Guardian

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Print Patient’s Name or Legal Guardian Date

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