Arrowhead HEALTH CENTERS | Accredited by the OsteoArthritis Centers of America

CONSENT TO DISCLOSE PHI

I hereby give my consent for Arrowhead Health Centers to use and disclose my Protected Health Information (PHI) to implement Treatment, Payment and Health Care Operations (TPO).

By signing below, I agree to all of the terms and conditions discussed within the Notice of Privacy Practices. I acknowledge that I have a right to review the Notice of Privacy Practices prior to giving my consent to the terms of this document, and if I wish to read the Notice of Privacy Practices, it is my responsibility to request a copy from the Arrowhead Health Centers check-in staff.

- □ With my consent, Arrowhead Health Centers may call the phone number listed below and leave a message in reference to appointment reminders, insurance information laboratory test results, my clinical care and other items that assist the practice in implementing TPO.
- □ With my consent, Arrowhead Health Centers may send mail to the address below in reference to appointment reminders, insurance information laboratory test results, my clinical care and other items that assist the practice in implementing TPO. All classified information pertaining to my medical records will be marked "Personal and Confidential."
- □ With my consent, Arrowhead Health Centers may send e-mail to the address below in reference to appointment reminders, insurance information laboratory test results, my clinical care and other items that assist the practice in implementing TPO.

I have the right to request that Arrowhead Health Centers 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 Arrowhead Health Centers 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.

_____ _____

Preferred Phone Number (000-000-0000) **Street Address**

_____ _____

E-mail Address **City, State, Zip**

_____

By signing below, I acknowledge that I have read and understand the above policy and I give my consent to the terms discussed therein.

_____ _____

Patient Last Name, First Name (Please Print) **Date of Birth (MM/DD/YYYY)**

_____

Signature of Patient or Responsible Party

_____ _____

Relationship to Patient (If Other Than Self) **Today's Date (MM/DD/YYYY)**