

Patient Consent for the Use and Disclosure of
Protected Health Information

This is my consent for SportsMED Orthopaedic Specialists, P.C. to:

_____ Call my home or call/text my mobile phone and leave a message on voicemail, or in person, to remind me of appointments or to obtain insurance information. We have an automated service that will call and remind you of your appointment date and time.

_____ Call and leave reports of my clinical care or lab results.

_____ E-mail me using my personal or other designated email address with appointment reminders and other matters related to my clinical care.

_____ Mail items that assist in carrying out my treatment, payment, or health questions, such as appointment reminder cards and patient statements to:

My home

Other designated location: _____

This is my consent for information regarding my general health and treatment to be discussed with the following people. Please print their full name and telephone number:

This is my consent for information regarding my health and treatment to be discussed with the following people in the event of an emergency. Please print their full name and telephone number.

By signing this form, I am consenting to SportsMED Orthopaedic Specialists, P.C. use and disclosure of my protected health information to carry out treatment, payment, and healthcare operations. I may revoke my consent in writing except on those disclosures made prior to my consent. I understand that SportsMED Orthopaedic Specialists, P.C. reserves the right to refuse to treatment if I do not sign this form.

Patient's Name, Printed

Date

Signature of Patient or Legal Guardian