Grants Pass Podiatry

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PODIATRIC PHYSICIANS AND SURGEONS
1227 NE 7th St., Ste. A; Grants Pass, OR 97526
Phone: 541-471-3668 Fax: 541-471-4814

CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

Name _____ Date of Birth _____

I authorize Grants Pass Podiatry to use and disclose the health and medical information of the patient named above for the purposes of treatment, payment, and health care operations as defined below:

Treatment (includes services performed by a physician, nurse, office staff and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers our practice by telephone as the on-call physician.)

Payment (includes activities involved in determining your eligibility or health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, recertification and preauthorization.)

Healthcare Operation (includes the necessary administrative and business functions of our office.)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please review the Notice for additional information about the uses and disclosures of information described in this consent. Initial here to verify that you have received a copy of Grants Pass Podiatry's Notice of Privacy Practices (included with this packet). _____

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Privacy Notice may change also.

As more fully explained in the Privacy Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment and health care operation purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment.

RELEASE OF INFORMATION TO FAMILY AND FRIENDS

Your medical information can only be released to friends and family if you list their names and the type of information they may receive below. Please list here anyone you would like to have access to this information:

Name	Medical and/or Financial information to be released

I understand that I have the right to revoke this consent provided that I do so in writing, except to the extent that Grants Pass Podiatry has already used or disclosed the information in reliance on this consent.

ACKNOWLEDGMENT

I understand the above information and the Notice of Privacy Practices and agree to abide by it.

Patient Signature _____ Date _____

OR Signature of Legal Guardian _____ Date _____