

HIPAA CONSENT FORM

For Use and Disclosure of Protected Health Information (PHI) for Treatment, Payment or Healthcare Operations (TPO)

I understand as part of my healthcare, **DR BRENDAN LEE PC** will originate and maintain health records describing my medical history, symptoms, examinations, test results, diagnosis, treatment and any plans for future care and treatment. I understand, also, this information serves as:

- A basis for planning my care and treatment;
- A means for communication among the many healthcare professionals who may contribute to my care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third party payor can verify that services billed were actually provided; and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a **NOTICE OF PRIVACY PRACTICES** which provides a more complete description of information uses and disclosures. I understand I have the right to review this notice prior to signing this consent form. I, also, understand that **DR BRENDAN LEE PC** reserves the right to change his privacy notice and practices.

I understand I have the right to restrict how my health information may be used or disclosed to carry out treatment, payment or healthcare operations (TPO) unless it is medically necessary or a medical emergency.

With this consent, **DR BRENDAN LEE PC** may:

- Call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, or any other information pertaining to my care including laboratory or test results.
- Mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements, insurance items or any other correspondence as long as they are marked Personal and/or Confidential.
- E-mail to me appointment reminders, insurance items or other correspondence pertaining to my care including laboratory or test results.

By signing this form, I am consenting to Dr. Brendan Lee, DC full use and disclosure of my PHI to carry out his TPO.

I may revoke my consent, in writing, except to the extent the practice has already made disclosures in reliance upon my prior consent. IF I DO NOT SIGN THIS CONSENT Dr. Brendan Lee, DC MAY DECLINE TREATMENT TO ME.

Print Patient Name: _____

Signature of Patient or Legal Guardian: _____

Date: _____