

**MEDICAL ARTS FAMILY PRACTICE
T. SCOTT WEBB, D.O.**

Consent to Use and Disclosure of Protected Health Information for Purposes of Treatment, Payment, and Health care Operations

As a condition of providing treatment to you, Medical Arts Family Practice must obtain your consent to use and disclose protected health information about you to carry out treatment, payment and health care operations. Please refer to Medical Arts Family Practice's Notice of Privacy Practices for a more complete description of such use and disclosures. You have the right to review the Privacy Notice prior to signing this consent.

- In accordance to the law, Medical Arts Family practice has reserved the right to revise its Notice of Privacy Practices at anytime. You may obtain a copy of the current Privacy Notice and any revised notice by written or verbal request at our office.
- You have the right to request Medical Arts Family Practice to restrict the manner in which your health information is used or disclosed to carry out treatment, payment, or health care operations. Our office however, is not required to agree to such restrictions. In the event that the request is agreed upon by Medical Arts Family Practice, the request will be bound by this agreement.
- You have the right to revoke this consent at anytime by notifying Medical Arts Family Practice in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent.

PLEASE ANSWER THE FOLLOWING QUESTIONS:

- I authorize MAFP to discuss or disclose protected health information (including treatment, payment, and other healthcare operations) to the following individuals:

Name _____ Relationship _____ Ph# _____

Name _____ Relationship _____ Ph# _____

Name _____ Relationship _____ Ph# _____

- I want my medical correspondence and /or billing statements mailed to my home address unless as indicated below. Please list address if not to be sent to your home address:

- I consent to MAFP leaving messages on my answering machine (including appointments, reminders or messages to call office) **YES** **NO**

- I wish to be contacted at a different telephone other than my home phone **YES** **NO**
(NOTE: Please be advised that cellular phones are not secure and private lines) ph# _____

- MAFP has my permission to contact me at work. **YES** **NO**

I hereby consent to the use and disclosure by Medical Arts Family Practice, its workforce, and its business associates of my protected health information for purposes of treatment, payment, and health care operations.

I acknowledge that I have received a copy of the Medical Arts Family Practice's Notice of Privacy Policy. This original document will become a permanent part of my Medical Record.

PATIENT NAME/ GUARDIAN: _____

SIGNATURE: _____

DATE: _____ DATE OF EXPIRATION: _____ NONE*

*You can always revoke your consent with written authorization.