Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Vincent Vein Center (VVC) to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by VVC describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. VVC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Vincent Vein Center, 601 Center Avenue, Grand Junction, CO 81501.

With this consent, VVC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, VVC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, VVC may e-mail to the address I provided any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that VVC 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 VVC 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.

With this consent, VVC may discuss my PHI (including treatment plan, insurance, and payment details) with my spouse/family member or entity:

_____

Person or Entity Name

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

_____ _____ _____

Signature of Patient or Legal Guardian Date Print Patient's Name