Patient Consent Form for Use and Disclosure of Protected Health Information

By signing this Consent Form, you give us permission to use and disclose protected health information about you for treatment, payment, and healthcare operations except for any restrictions specified below to which we have agreed. *Protected health information* is individually identifiable information we create or receive, including demographic information, relating to your physical or mental health, for provision of healthcare services to you, and to the collection of payment for providing healthcare services to you.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to receive a copy of our Notice of Privacy Practices before signing this Consent Form. As provided in our Notice, the terms of the Notice of Privacy Practices may change. If we change our Notice, you may obtain a revised copy by contacting our information Privacy Officer at 970-416-6286, who is also available to respond to any questions or receive any complaints you may have concerning your protected health information.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. ***We are not required to agree to any restrictions, but if we do, we are bound by our agreement.*** If you wish to make a restriction, please request a copy of our Form to Request Restrictions.

If you do not sign this Consent form, we have the right to refuse you treatment unless a licensed healthcare professional has determined that you require emergency treatment or we are required by law to treat you. We are required to document any circumstances in which we do not obtain your consent, yet carry out treatment. We will offer you a copy of this documentation should you decide not to sign this Consent Form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. You may request to use our Authorization for Release of Information Form for purposes of requesting your revocation, or you may simply send us a letter in writing.

_____ _____

PRINT PATIENT NAME DATE OF BIRTH

_____

PRINT PATIENT PERSONAL REPRESENTATIVE NAME

_____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

_____

DATE OF SIGNATURE

This consent form references our Privacy Policies dated 4-14-03

*** PERMISSION REGARDING DISCLOSURE OF YOUR/YOUR CHILD'S HEALTHCARE INFORMATION ***

I hereby authorize Pediatric Urgent Care of Northern Colorado to speak to the individual(s) named below regarding my/my child's protected health information (optional):

NAME: _____ Relationship to Patient: _____

NAME: _____ Relationship to Patient: _____

*** MAY WE LEAVE DETAILED HEALTH INFORMATION ON YOUR VOICEMAIL? ***

YES: ___ Phone Number: _____ NO: ___