

# Dr. Mel Youngs D.C., PA & Associates

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## PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

### THIS CONSENT FORM ENSURES PRIVACY OF YOUR PROTECTED HEALTH INFORMATION

I, \_\_\_\_\_, hereby state that by signing the Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that , and consent to, the following appointment reminders that will be used by the Practice: a) telephoning my home or place of employment and leaving a message on my answering machine or with the individual answering the phone b) emailing a reminder to the email address provided.
4. This practice uses a sign in log for individuals seeking care and treatment in the office. I understand that this information may be seen by, and is accessible to, others who are seeking care or services in our office.
5. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
6. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

Protected Health Information and Account Information may be released to: Name \_\_\_\_\_  
Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

7. I understand that this Consent is valid and will remain in effect until I revoke it. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
8. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
9. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

**I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Signature of Legal Representative**

\_\_\_\_\_  
**Relationship**

\_\_\_\_\_  
**Date**