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New Castle, PA 16105
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PATIENT CONSENT FORM

** Please Read and Answer Each Question **

1. If you want your medical information continued to be handled the same way,

   Please Sign Here: _____

2. Persons authorized to receive non-specific information about you: i.e. appointment times/dates

   _____ _____ _____

3. How may we contact you? (if SAME, please state so) _____

4. Persons authorized to receive all private information, including test results and diagnosis: (if you write NO ONE, be advised that no information will be given, other than to the patient)

   _____

   _____

   _____

   _____

We are very concerned with protecting your privacy. While the law requires us to provide you with this disclosure, please understand that we have, and always will respect the privacy of your health information.

HIPAA guidelines state that, unless you tell us not to, we may tell callers certain general information about you, for example: your appointment date/time, prescriptions instructions, etc. We do not give out information such as diagnosis, test results, even for family members. With HIPAA, you are able to instruct us on exactly who you want this information given to.

Using these guidelines, this office is required to give all patients this opportunity:

1. How do you want contacted – i.e. specific phone numbers, addresses, postcard reminders, etc.
2. Who you want us to give your protected health information (PHI) to. This does not include the PHI for billing insurance companies, routine office procedures (ex: scheduling tests/appointments/surgery,etc),or notifying law enforcement agencies when necessary.

You may request to change these instructions by sending us a written request, or by filling out a new disclosure sheet.