Lifetime Insight, LLC
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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name of Patient: _____ Date: _____

I hereby give my consent for Lifetime Insight, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Lifetime Insight LLC's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Lifetime Insight, LLC reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Lifetime Insight LLC's Privacy Officer at 440 Regency Parkway Dr., Suite 136, Omaha, NE 68114.

With this consent, Lifetime Insight, LLC may call my home or other alternative location and leave a message on voicemail 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 results, among others.

With this consent, Lifetime Insight, LLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as patient statements so long as they are marked Personal and Confidential.

With this consent, Lifetime Insight, LLC may e-mail to me any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements.

I have the right to request that Lifetime Insight, LLC restrict how it uses or discloses my PHI to carry out TPO. However, 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 Lifetime Insight, LLC's use and disclosure of 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. If I do not sign this consent, or later revoke it, Lifetime Insight, LLC may decline to provide treatment to me.

_____

(Signature of Patient)

OR

_____

(Signature of guardian or authorized representative) (Relationship to patient)