Date: ___/___/___

<u>Patient:</u> ________________________________ M/F
Address: _______________________________
____
____
Email: _______________________________

Date of Birth: ___/___/____
SSN: _____-____-_____
Home #: (___)____-_____
Work #: (___)____-_____
Cell #: (___)____-_____

<u>Person Responsible for the Account</u> (If other than self)
Name: ____________________________________
Address: __________________________________
____

Relationship to patient:__________
Phone #: (___)____-_____

<u>Primary Insurance:</u>
Policy Holder/Insured:_______________________
Employer:_________________________________
Insurance Co:______________________________
Mail to: ____________________________________
____

Date of Birth: ___/___/____
SSN: _____-____-____
Ins. ID # :______________________
Group#: _______________________

<u>Secondary Insurance:</u>
Policy Holder/Insured:_______________________
Employer:________________________________
Insurance Co:_____________________________
Mail to: ___________________________________
____

Date of Birth: ___/___/____
SSN: ____-____-___
Ins. ID #: ______________________
Group#: _______________________

Who can we thank for referring you to our office? ________________________________

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

By signing below, I give my consent to use or disclose my protected health information to carry out treatment, payment activities and heath care operations.

Your consent permits us to do the following: (Please keep in mind that none of these are new practices)

- Communicate between staff members for your optimal care
- Contact a referral doctor on your behalf
- Phone in a prescription to your pharmacy
- Call your home, cell or work number
- Mail, email or text correspondence
- Have prosthetic prescriptions completed by our labs
- Submit claims to insurance
- Other health care-related functions

You have the right to read our Notice of Privacy Practices before you decide to sign this form. Our notice provides a description of our treatment, payment activities and health care operations, of these uses and disclosures we may make of your protected health information, and of other important matter about your protected health information. You may have a copy of the notice upon request.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we do so, we will issue a revised notice containing changes.

You have the right to restrict or revoke this consent upon written notification, however the office is not obligated to agree to the restriction and the restriction/revocation will not be effective prior to the date of receipt of notice.
I give my permission for the office to also speak/contact the following person(s) about my health:
Name: __________________ Relationship: ________________
Name: __________________ Relationship: ________________
Name: __________________ Relationship: ________________

Signed: ____ Date: ____/________/______