WhisperingFalls

Patient Consent for use and Disclosure of Protected Health Information

I hereby give my consent for Whispering Falls to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Whispering Falls describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Whispering Falls reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Whispering Falls Attn: Privacy Officer, 13701 E. Sprague Ave. Spokane Valley, WA 99216.

With this consent, Whispering Falls may call my home or other alternative location and leave a voice mail or in person 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 test results, among others.

With this consent, Whispering Falls may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Whispering Falls may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Whispering Fall restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Whispering Falls to use and disclose 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, Whispering Falls may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Print Patient's Name Date

**Names of People that you would like to have full access to your PHI (such as billing information, appointments, and health records).

_____ _____

Name of Person & Relationship to insured Name of Person & Relationship to insured

_____ _____

Name of Person & Relationship to insured Name of Person & Relationship to insured