

KELLER FAMILY MEDICAL CENTER
Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Keller Family Medical Center 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 Keller Family Medical Center describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Keller Family Medical Center 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 Privacy Officer, 808 Keller Parkway, Keller, Texas 76248.

With this consent, Keller Family Medical Center 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 as long as they are marked "Personal and Confidential".

I have the right to request that Keller Family Medical Center restrict how it uses or discloses my PHI to carry out TPO. 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 allow Keller Family Medical Center to use and disclose my protected health information to carry out treatment, payment and healthcare operations.

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, Keller Family Medical Center may decline to provide treatment to me.

Signed by: _____ Date: _____ Relationship to Patient: _____

Print Patient's Name: _____ Print Name of Legal Guardian, if

Applicable _____

I have been provided a Keller Family Medical Center practice information handout.

Signed by: _____ Date: _____

Relationship to Patient: _____

CONTINUED ON BACK

PHONE MESSAGE CONSENT

From time-to-time in caring for our patients, it may be necessary or desirable to contact patients by phone. When you are not available for us to speak to directly, we like to leave messages where possible.

In order to protect your privacy we have developed a policy on leaving messages:

We will not discuss any medical information with anyone except the patient or legal guardian.

We will not leave any medical information on an answering machine.

We will not leave any medical information on a voice mail system.

We will attempt to, as a courtesy, leave a reminder message regarding an upcoming appointment.

UNLESS

We have your written permission to leave messages for you. Please read the information below and consider carefully whom you want to have access to your medical information, such as test results. Please fill out only **ONE** of the following sections below to make your preferences known.

A. I **DO** consent to leave detailed messages:

I, _____ give Keller Family Medical Center permission to leave phone messages regarding my medical care with the following: (Initial for each one you wish to have your messages). This consent will remain in effect until rescinded in writing.

My home phone answering machine number _____ Initials _____

My cell phone voice mail number _____ Initials _____

My spouse (name) _____ Initials _____

Other (name) _____ Phone# _____ Initials _____

Signature _____ Date _____

B. I **DO NOT** consent to leave detailed messages:

I, _____ wish to be contacted personally and I do not authorize detailed messages regarding my medical care to be left on an answering machine, cell phone or with others.

Signature _____ Date _____

C. Revocation of prior consent

I, _____ wish to rescind the above authorizations.

Signature _____ Date _____