

Please Print Name: _____

Date of Birth: _____

I. Permission for Verbal Disclosure

I, the undersigned, authorize Boone County Family Medicine to verbally disclose my Protected Health Information to the following individual(s) or entities. I understand that this permission only applies to verbal communication to include, but not limited to discussion of my treatment plans, medications, test results, and upcoming procedures. I further understand that disclosure of copies of my medical record, or other written forms of my protected health information, will require my written authorization for each episode of release. This permission will become a permanent part of my medical record.

Name: _____ Phone# _____

Relationship: _____

Name: _____ Phone# _____

Relationship: _____

Name: _____ Phone# _____

Relationship: _____

Name: _____ Phone# _____

Relationship: _____

Please check the areas that you wish the individual / entity named above may receive oral disclosures about:

- ___ Treatment plans, medications, test results, and upcoming procedures ___ Mental health
- ___ Substance Abuse information ___ Billing information ___ HIV ___ Genetic information
- ___ Appointment Information/Rescheduling ___ Other (specify): _____

II. Permission for Boone County Family Medicine to Leave a Message

Is it okay for Boone County Family Medicine to leave a message containing our contact information?

- No – please do not leave a message on any answering system
- Yes – message left on my home answering machine; work answering machine; cell phone answering machine

Home Phone # _____ Work Phone # _____ Cell Phone # _____

I understand that a written revocation will be necessary for documentation purposes. Other than revocation, any changes requested will require written notification to Boone County Family Medicine. I also understand that any release made prior to my revocation which was in compliance with this authorization shall not constitute a breach of my rights to confidentiality.

III. Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, acknowledge that I have received a copy of the Notice of Privacy Practices of Boone County Hospital and/or its affiliates, which summarizes the way my identifiable health information may be used and disclosed by the Provider and states my rights with respect to my medical information. I understand the Provider has the right to revise these information practices and to amend the Notice of Privacy Practices. I have been informed that in the event the Provider revises its information practices, a revised Notice will be posted at the main office and that I may obtain a current Notice of Privacy Practices at any time from the Privacy Officer.

IV. Consent and Authorization

Medical Care – I hereby consent to the rendering of such care which may include routine diagnostic procedures and such medical treatment as the physician or other medical staff consider to be necessary. I understand the practice of medicine and surgery is not an exact science and diagnosis and treatment may involve risks of injury, or even death. I acknowledge that no guarantees have been made to me as to the result of examination of treatment in this clinic. I understand that: (a) it is customary, absent emergency or extraordinary circumstances, that no substantial procedures are performed upon patient unless and until he/she has an opportunity to discuss them with the physician or medical staff, (b) each patient has the right to consent or refuse consent to any proposed procedure of therapeutic course; and (c) no patient will be involved in any research or experimental procedure without his or her full knowledge and consent.

Financial Agreement – It is my understanding that there will be a separate charge by the Radiologist and Pathologist for the services, which will be billed directly by each when radiological and pathological procedures are ordered by my examining, treating or referral physician. I agree to pay for those charges. I understand it is my responsibility to pay any amounts not covered by insurance at the time of my office appointment. I hereby authorize payment of benefits directly to Boone County Family Medicine and authorize Boone County Family Medicine to furnish information to other providers of services for billing and insurance purposes. By providing us with your wireless/cell phone number, you are hereby granting us, and our agents or independent contractors, your consent to receive calls on your wireless/ cell phone number for billing and debt collection purposes.

Patient/Legal Representative Signature: _____ Date: _____

Expiration One Year from Date Above

Relationship if other than patient: _____