

**Front Royal Family Practice, PC
140 West 11th Street
Front Royal, VA 22630
CONSENT FORM**

**(For Use and Disclosure of Protected Health Information for Treatment, Payment, or
Healthcare Operations)**

I understand that as part of my healthcare Front Royal Family Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a **Notice of Information Practices** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand the practice reserves the right to change their notice and practices, and prior to implementation, will mail a copy of any revised notice to the address that I have provided if there is a need to use or disclose any protected health information. I also understand that I have the right to restrict as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the practice is not required to agree to the restrictions requested, other than the exception noted in the **Notice of Information Practices**. I understand that I may revoke this consent in writing, except to the extent that the practice has already taken action in reliance thereon. Any patient, guardian or personal representative has the right to receive confidential communications of protected health information by alternative means or at alternative locations. Such request must be in writing and the practice must accommodate reasonable request.

With this consent, Front Royal Family Practice may call my home or other designated location and leave a message on 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 call pertaining to my clinical care, including laboratory results among others.

With this consent, Front Royal Family Practice may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and other correspondence as long as they are marked Personal and Confidential.

With this consent, Front Royal Family Practice may e-mail to me appointment reminders and patient statements. I have the right to request that Front Royal Family Practice restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions except for a request for a restriction on a disclosure to a health plan where services have been paid in full, out-of-pocket, but if it does, it is bound by this agreement.

By signing this form, I am consenting for Front Royal Family Practice to use and disclose my PHI to carry out my 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, Front Royal Family Practice may decline to provide treatment to me.**

Print Patient Name: _____

Account Number: _____

Signature of Patient or Legal Guardian: _____

Date: _____