your family doktors

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PATIENT CONSENT FORM

I allow release of medical information to the following: (Please check all that apply)

- ☐ No one except myself
- ☐ Spouse: _____
- ☐ Other: _____

I allow the following person(s) to pick up prescriptions on my behalf, with appropriate ID:

_____

_____

_____

		Okay to Leave Voicemail / Check preferred (If not selected YFD will leave a voicemail)
Home Phone		Yes No
Cell Phone		Yes No
Work Phone		Yes No

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment):
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I also have been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time, and that I may contact you at any time to obtain the most current copy of this notice.

I have read and received a copy of Your Family Doktors policies.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date that I revoke this consent is not affected.

Print Patient Name: _____. Relationship to Patient: _____.

Signature: _____. Date: _____