Privacy Consent

Sound Health Care CENTER

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGMENT OF RECEIPT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Sound Health Care Center. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

Signature of patient or legally authorized individual _____ Date (mm/dd/yyyy) _____

PRIVACY CONSENTS

I agree to permit Sound Health Care Center to request and obtain previous medical records from or forward records to other providers if deemed necessary to provide me with proper care and treatments.

I agree to the release of all my insurance and medical information to other health care providers, my insurance company, Medicare, or any third party payer to facilitate health care, processing of claims, and audit of payments. I understand that the information released may need to include records regarding HIV/AIDS, sexually transmitted disease, mental health, and drug and alcohol abuse treatment health information.

I agree to be contacted regarding treatment options and health-related benefits regarding medical options that may improve my quality of life.

I agree to be contacted for routine appointments or follow-up information regarding my care by:

Method		Initials	Detailed?	Method		Initials	Detailed?	Method		Initials	Detailed?
Cell Phone	☐			Home Phone	☐			Work Phone	☐		
US Mail	☐			Patient Portal (secure)	☐			Email (unsecure)	☐		

I agree to allow the practice to use and disclose information regarding my care as needed.

Please list individuals you wish to participate in your care:

The individuals listed here will be considered the only individuals you wish for us to communicate with regarding your care. If these individuals are not available in an emergency situation, we may need to use our discretion regarding use and disclosure of your medical information.

Full Name and relation _____ Phone: ☐ Home ☐ Work ☐ Cell _____ Yes No May we leave details w/ this person?

Full Name and relation _____ Phone: ☐ Home ☐ Work ☐ Cell _____ Yes No May we leave details w/ this person?

Full Name and relation _____ Phone: ☐ Home ☐ Work ☐ Cell _____ Yes No May we leave details w/ this person?

Full Name and relation _____ Phone: ☐ Home ☐ Work ☐ Cell _____ Yes No May we leave details w/ this person?

These consents will remain in effect until revoked by me in writing. ☐ _____ Initials

Signature of patient or legally authorized individual _____ Date (mm/dd/yyyy) _____

Print Name if signed on behalf of the patient _____ Relationship to Patient _____