PRIMECARE CONSULTING, LLC
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Privacy/Compliance Officer: Stacie Scopo
(816) 442-7141
Effective 6/18/14

INDIVIDUAL PATIENT'S AUTHORIZATION

This form is to confirm your notification of Privacy Practices and authorization to use or disclose your protected health information for a special purpose.

☐ I have received the Notice of Privacy Practices and have been given an opportunity to review it.

I, _____ give my authorization to use or disclose my protected health information as described below:

Records including notes of office visits, procedures and diagnostic tests may be disclosed to providers involved in my care and insurance companies responsible for payment for their use in coordinating my medical care and to facilitate authorization and/or payment for needed care.

I understand that PrimeCare Consulting will communicate with me by telephone at my home/cell/work and may leave messages with detailed information unless I direct them otherwise.

I understand that I may revoke this authorization at any time by giving notice to the Compliance Officer. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has the right to contest my claims under the insurance policy.

I understand that under most circumstances a doctor may not condition treatment or payment on my signing this authorization. I understand I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for disclosure to a third party.

This authorization will end when the following event occurs, provided event relates to the individual or the purpose of the authorized use or disclosure **OR** on the following date:

_____

I have had a chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that by signing this form I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the entities named in this form.

Signature: _____ Date: _____

If this authorization form is signed by a personal representative for the individual patient:

Personal representative's name: _____

Personal representative's signature: _____

Relationship to Individual Patient: _____

You have a right to have a copy of this form after you sign it.