CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

At Team Chudy LLC, we may use or disclose personal information and health related information about you the following ways:
We may have to use or disclose your personal health information to another healthcare provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
We may have to disclose your health information and billing records to another party, such as an insurance carrier, an HMO, a PPO or your employer, if they are or may be responsible for the payment of your services.
We may need to use your health information within our practice for quality control or other operational purposes.
We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices we will notify you in writing when you come in for treatment or by mail.
You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your relocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice and a copy of your Privacy Notice.

Printed Name	Signature	Date	Witness	Date

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

We at Team Chudy LLC may need to use your name, address, phone numbers, and your clinical records to contact you with appointment reminders, missed or new appointment scheduling, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine, voicemail or with a member of your household. By signing this form you are giving us authorization to contact you with these reminders and information and to leave messages on your answering machine, voice mail or with individuals at your home or place of employment.
You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.
Information that we use or disclose based on the authorization you are giving us may be subject to redisclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules. You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect treatment we provide to you or the methods we use to obtain reimbursement for your care.
This notice if effective as of _____. This authorization will expire seven years after the date on which you last received services from us. I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

Printed Name	Signature	Date	Witness	Date