SEACOAST HAND THERAPY

CONSENT FORM

For Use and Disclosure of **P**rotected **H**ealth **I**nformation *(PHI)*
as well as for **T**reatment, **P**ayment, or Healthcare **O**perations *(TPO)*

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

- A basis for planning my care and treatment.
- A means of communication among the 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.

With this consent, *Seacoast Hand Therapy* 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 (treatment, payment, & operations), such as appointment reminders, insurance items and any information pertaining to my clinical care.

With this consent, *Seacoast Hand Therapy* may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders, account statements, and other correspondence.

Seacoast Hand Therapy may e-mail correspondence to me related to my healthcare provided at this facility. I have the right to request that *Seacoast Hand Therapy* restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I understand that I have the right to restrict my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that *Seacoast Hand Therapy* is not required to agree to the restrictions requested.

I may revoke my consent in writing except to the extent that *Seacoast Hand Therapy* has already made disclosures in reliance upon my prior consent.

By signing this form, I am consenting to *Seacoast Hand Therapy* to use and disclose my PHI to carry out my TPO. We encourage you to read the *Notice of Privacy Practices* that is available to you at the front desk prior to signing this consent.

If I do not sign this consent, Seacoast Hand Therapy may decline to provide treatment to me.

Print Patient Name _____

Signature of Patient or Legal Guardian _____Date:_____

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