Northern Pines Orthopaedic Clinic
CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
SIGNATURE CONSENT FORM

Patient Account #___________ Patient Name______________________________ NPOC DR ________

1. Permission to Use and Disclose Your Health Information. By signing this consent, you authorize us to use and/or disclose your health information for treatment, payment or health care operations such as appointment to other treating providers for tests and referrals. You have the right not to sign this consent. However, if you refuse to sign this consent, we have the right to refuse to treat you.

2. Your Rights With Respect to This Consent.

   2.1. Right to Review Notice of Privacy Practices. We have provided you, along with this consent form, a copy of our Notice of Privacy Practices ("Notice") which details how we may use and disclose your health information. You have the right to review this Notice before signing this consent. We may amend the Notice from time to time. You may obtain a copy of our Notice, including any revisions we have made by contacting *HIPAA Officer, 218-326-6677, 111 Golf Course Road, Grand Rapids, MN 55744*

   2.2 Right to Request Restrictions on Use/Disclosure. You have the right to request that we restrict how we use and/or disclose your health information for the purpose of providing treatment, obtaining payment for our services, and/or conducting health care operations. Such requests must be made in writing. Please note that we are not *required* to agree to any restriction you may request. If, however, we agree to a restriction you have requested, we must restrict our use and/or disclosure of your health information in the manner described in your request. To obtain a restriction request form, please contact *HIPAA Officer, 218-326-6677, 111 Golf Course Road, Grand Rapids, Minnesota, 55744.*

   2.3. Right to Revoke Consent. You have the right to revoke this consent at any time. Your revocation of this consent must be in writing. If you wish to revoke this consent, please contact, HIPAA Officer, 218-326-6677, 111 Golf Course Road, Grand Rapids, MN 55744 to obtain a revocation form. Note that your revocation of this consent will not be effective for disclosures we have already made in reliance on your prior consent. We also have the right to refuse to provide further treatment if you revoke this consent.

   2.4 Right to Receive a Copy of This Consent Form. You have a right to receive a copy of this consent form after you sign it.

3. Effective Period. This consent is effective on the date of signing and shall remain in effect indefinitely, unless you revoke it earlier in writing.

I authorize the release of medical and billing information including physician notes and reports, my address, phone number, birthday and if required my social security number (SS# is required for work comp and government programs), to be released to my insurance company, its agents, the Centers for Medicare and Medicaid services or its intermediaries, my employer (for workers compensation only) and other physicians involved in my care. I authorize the release of all of the above in both written and electronic format. I permit a copy of this authorization to be used in place of the original. The release of this information will only be used for treatment and diagnosis purposes. This information will not be released to any third party. I authorize all of my insurance company's payments to be sent directly to the clinic.

I consent to office procedures that are deemed necessary including injection, aspiration, fracture reduction and manipulation. I understand that any recommended procedures will be explained to me along with any risks and benefits of such procedures and I will have the opportunity to ask any questions regarding these procedures. I hereby authorize *Northern Pines Orthopaedic Clinic, P.A.* to use and/or disclose my health information for treatment, payment and for health care operations.

Signature_________________________Guardian_________________________ Date______________

I authorize clinic personnel to leave messages of a medical nature on my answering machine in the event that I am not at home. **Yes__ No__ phone number to leave messages (218) ____________**

We automatically send notes to your family physician, if you prefer we don't, please write NO here ______