



**Patient Consent for Use and Disclosure of Protected Health Information**

I hereby give my consent to the physician, his/her authorized designee, or medical record personnel, hospital, laboratory, diagnostic center, other physicians and/or their authorized designees to release my protected health information; which could include alcohol and drugs abuse records, behavioral medical services and any information regarding communicable diseases and infections, including venereal disease, HIV/AIDS, to use request and disclose Protected Health Information (PHI) about me to carry out treatment, payment and health care operations (TPO); to the following individual and/or organization:

**Kaydokte Health Organization**

Prior the signature of this consent, I have the right to review the Notice of Privacy Practice, which describes such uses and disclosures completely and it is provided by the above mentioned individual or organization. I understand that my protected health information disclosed under this authorization may be subject of re-disclosure by the individual or organization name above. With this consent, the organization may, in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others:

- o Call my home or other alternative location and leave a message on voice mail or in person
- o Mail to my home or other alternative location any items as long as they are marked "Personal and confidential."
- o E-mail to my home or other alternative location

EHR Health data sharing

Patient Consent to Record Sharing  Yes  NO

I have the right to revoke this authorization, in writing, at any time except to the extent that the practice has already made disclosures in reliance upon my prior consent. In order for the revocation of this authorization to be effective, must be in writing and delivered by hand or certified mail and it should include patient's name, date of birth, social security number, address, patient's desire to revoke this consent and must be dated and signed. I also understand that, if I do not sign this consent, or later revoke it, the individual or organization above mentioned may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Date