Tele-Behavioral Medicine Assoc.

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Behavioral Medicine - Pain Management - Telemedicine Consultation and Programs Development - Clinical Pharmacology

PATIENT CONSENT FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name: _____ **Date:** _____

I understand that my (the patient's) health information is private and confidential and that Herbert A. Schwager, Ph.D., DBA Behavioral Medicine Associates ((BMA)) will endeavor to protect and preserve the confidentiality of my personal information.

I further understand that (BMA), with my expressed permission, may use and disclose parts of my (the patient's) health information while providing treatment to me (the patient), in an effort to assist billing of third party payers' and to address other healthcare operations in their effort to assist my overall best interest.

I understand that (BMA) has available for my review, a detailed document called the *Notice of Privacy Practices.* It contains more detailed information about how this office may use and disclose my health information. I understand that I have a right to read the Notice before I sign this consent.

I understand that (BMA) may update this Notice from time to time. If I ask, this office, it will provide me with the most current Notice.

I understand that under the terms of this consent, I may ask (BMA) to restrict how my (the patient's) health information is used or how it is disclosed to carry out treatment, payment, or healthcare operations. I understand that this office does not have to agree to my (the patient's) request. If this office does not agree to my (the patient's) request, I understand that this office will follow those limits previously agreed to and/or allow and respect my right to resend this or previous signed consents.

I understand this consent shall be in force and effect as long as I am a patient of (BMA) unless I chose to revoke it. I understand that I may revoke this consent in writing any time by writhing, signing and dating a letter to (BMA). If I write a letter, it must say that I want to revoke my (the patient's) consent to authorize the use and disclosure of my (the patient's) health information for treatment, payment, and healthcare operations.

I understand that if I revoke or refuse to sign this consent, (BMA) does not have to provide any further health care services to me (the patient).

The signature below indicates that I (the patient) have been given the chance to review a current copy of (BMA) *Notice of Privacy Practices.* The signature means that I (the patient) agree and consent to allow this office to use and disclose my (the patient's) protected health information in order to carry out treatment, payment, and health care operations.

Persons who may be given my private health information: _____

May we leave messages on your home phone: ☐ Y ☐ N ***work phone***: ☐ Y ☐ N ***cell phone***: ☐ Y ☐ N

_____ _____
Signature of Patient, or Personal Representative (Date)

_____
Relationship to Patient if signed by anyone other than the patient

_____ _____
Refused (Date)