Tri-City Orthopaedic Clinic, PSC

6703 W Rio Grande Ave	**821 Swift Blvd**	**965 Goethals Dr**
Kennewick, WA 99336	**Richland, WA 99352**	**Richland, WA 99352**
Ph: (509) 946-6144	**Ph: (509) 946-6144**	**Ph: (509) 946-6144**
Fax: (509) 783-5438	**Fax: (509) 946-7253**	**Fax: (509) 943-9521**

CONSENT FOR USE AND DISCLOSURE OF PRIVATE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Patient Name: ________________________________ **Date of Birth** ______________________

SSN: ______________________ **Previous Name (if any)** ________________________

My health information is a private matter. Tri-City Orthopaedic Clinic, PSC has a form that can tell me how his clinic handles my health care information. This form is entitled "Notice of Privacy Practices". If I ask, Tri-City Orthopaedic Clinic, PSC will provide me with the most current "Notice" before I sign this consent. I understand that the clinic may update this "Notice" at any time and that if I request it, I will receive a current copy of the "Notice".

I agree that Tri-City Orthopaedic Clinic, PSC may use and disclose my health information to help treat me, for insurance and billing related to my physician visits and for other health care operations such as appointment reminders, calling with results of laboratory tests and performing health quality improvements in the practice. I also understand that the law sometimes requires the release of health care information *without* my approval such as in cases of child abuse or neglect.

I may ask Tri-City Orthopaedic Clinic, PSC to further limit the use or disclosure of my health information and that I must do this in writing. The clinic is not required to agree to my request but will usually attempt to meet my restrictions.

I may cancel this consent at any time, by doing one of the following:

- Signing and dating a revocation form. I may get this form from the clinic;
- Writing, signing and dating a letter to Tri-City Orthopaedic Clinic, PSC which says that I cancel my consent to authorize the use and disclosure of my health care information for treatment, payment and health care operations.

If I cancel this consent:

- It will be effective except for actions already taken based upon the Consent: and
- Tri-City Orthopaedic Clinic, PSC will not have to provide any more health care services to me.

I have been given the chance to read a current copy of Tri-City Orthopaedic Clinic, PSC's "Notice of Privacy Practices". I agree to allow Tri-City Orthopaedic Clinic, PSC to use and disclose my health information to carry out treatment, payment and health care operations.

_______________________________________ ____________________

(Patient or legally authorized signature) Date

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Patient Name:_______________________________ Date of Birth _____________

SSN: _____________________ Previous Name (if any) _______________________

I no longer want Tri-City Orthopaedic Clinic, PSC to use and disclose health care information about me for treatment, insurance billing and payment and health care operations of the clinic.

I understand that:

- This request applies after I sign this document.
- Tri-City Orthopaedic Clinic, PSC may have already taken action based upon my earlier permission.
- Tri-City Orthopaedic Clinic, PSC is allowed by law to use and disclose my health care information to complete treatment, billing and payment and health care operations already in progress. I agree to this when I signed the "Consent for Use and Disclosure of Health Care Information".
- Tri-City Orthopaedic Clinic, PSC is required in certain situations to release health care information with out my consent.
- Tri-City Orthopaedic Clinic, PSC does not have to provide any further health care services to me.

_______________________________ _______________

(Patient or legally authorized signature) Date

____

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, etc)

Consent To Inform – Your Right to Privacy

**** PLEASE PRINT****

PATIENT'S NAME: ____

We respect your right to privacy regarding medical information. Without additional written consent, may share information with your spouse?
If yes, their name: ____

We understand you may have concerned relatives. Please list the names of adults, children, other family members and/or contact persons with whom we may share information, without additional written consent, and their relationship to the patient:
Check if N/A (not applicable): ____________

Name: _________________________________ Relationship to Patient: _________________________

Name: _________________________________ Relationship to Patient: _________________________

Name: _________________________________ Relationship to Patient: _________________________

Name: _________________________________ Relationship to Patient: _________________________

Name: _________________________________ Relationship to Patient: _________________________

Any persons you **DO NOT** want us to give medical information to please list on the lines below:
Check if N/A (not applicable): ____________

Name: _________________________________ Relationship to Patient: _________________________

Name: _________________________________ Relationship to Patient: _________________________

Name: _________________________________ Relationship to Patient: _________________________

**** If there are any changes to be made on this form it is the patient's responsibility to let us know at each occurrence.**

____
Signature of patient or patient's authorized representative Date:

____
Relationship or status if signed by anyone other than patient (parent, legal guardian, etc.)

THIS AUTHORIZATION WILL EXPIRE YEARLY, UNLESS OTHERWISE REVOKED.

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