

Plainville Medical Clinic

Patient Consent for Use and Disclosure of Protected Health Information

Effective Date 4.14.2003, Updated 3.27.2009

Plainville Medical Clinic is an amended Organized Health Care Arrangement agreement (OHCA) permitted to represent itself as such under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is comprised of Daniel J. Sanchez, MD, PA, LifeLine Family Medicine, PA and Prairie Star Family Practice, PA. This OHCA relates to clinic locations at 1210 North Washington, Plainville, KS 67663; 623 South Second, Stockton, KS 67669; and 505 Main Street, Palco, KS 67657. These named corporations are not to be construed as one for any other purpose than HIPAA Privacy Rules.

I hereby give my consent for Plainville Medical Clinic (PMC) to use and disclose my protected health information (PHI) to carry out treatment, payment, and health care operations (TPO). PMC's Notice of Privacy Practices provides a more complete description of such uses and disclosures. By signing this form, I am consenting to PMC's use and disclosure of my PHI to carry out TPO.

By signing this form, I agree that I have reviewed the Notice of Privacy Practices. PMC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by sending a written request to the office at 1210 North Washington, Plainville, KS 67663.

With this consent, PMC may call my home, or alternate phone numbers provided by me, and leave a message or speak in person regarding any items that assist the practice in carrying out TPO, such as appointment reminders, insurance information, and calls regarding clinical care.

With this consent, PMC may mail to my home, or alternate locations provided by me, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, so long as they are marked confidential.

I have the right to request that PMC restrict how it uses or discloses my PHI to carry out TPO. PMC will comply with my requests in good faith and to the best of its abilities.

By signing this form, I hereby authorize payment directly to the medical provider of benefits due me for the services rendered by a health care provider of PMC. I understand that I am responsible for charges not covered by this authorization.

I also understand that there may be times when my health care provider orders tests that my insurance deems unnecessary. I agree to be responsible for these charges.

I also understand that laboratory and radiology (x-ray) charges are separate from the health care provider's visit charge. Any questions I have about laboratory or radiology billing should be addressed directly to the billing facility.

I may revoke my consent in writing except to the extent that PMC has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, PMC may decline to provide treatment to me.

I certify that I have read and fully understand this document and have been given the option of receiving a copy of it. I, as the patient or legal guardian of the patient, indicate agreement with all the terms and statements above in signing this document.

Printed Patient Name

Signature of Patient/Legal Guardian

Signer's Relationship to Patient

Date Signed