

**WOODFIELD ORTHOPAEDICS & SPORTS MEDICINE, LTD.**

**PATIENT CONSENT FORM**

Woodfield Orthopaedics & Sports Medicine may contact me by phone with medical information regarding my treatment at any of the following numbers:

Home # (\_\_\_\_) \_\_\_\_\_

Work # (\_\_\_\_) \_\_\_\_\_

Cell # (\_\_\_\_) \_\_\_\_\_

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and/or indirectly

Obtain payment from third party payers

Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you and your Privacy Notice containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Privacy Notice by signing this consent. I understand that this organization has the right to change its Privacy Notice from time to time and that I may contact this organization at any time to obtain a current copy of the Privacy Notice.

I understand that, and consent to, the following appointment reminder that may be used:

Contact at home to leave a message on an answering device or with the individual answering the phone

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time to the extent that you have taken action relying on this consent.

I have read and understood the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Patient Name \_\_\_\_\_

Name of person responsible, if a minor: \_\_\_\_\_

Relationship \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_