

PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

With my consent, Hancock Physician Network may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Hancock Physician Network’s Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices, which may be obtained upon request.

With my consent, Hancock Physician network may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items , and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Hancock Physician Network may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and/or Confidential.

I have the right to request that Hancock Physician network restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Hancock Physician Network’s use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Hancock Physician Network may decline to provide treatment to me.

Patient’s Name

Date of Birth

Signature of Patient or Legal Guardian

Date

Print Name of Legal Guardian (if not patient)