

Head to Toe Family Healthcare
735 N. 5th Street
Silsbee, TX 77656
(409)385-6500 (409)385-6505 Fax

PATIENT CONSENT
FOR THE USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Head to Toe Family Healthcare to use and disclose my Protected Health Information (PHI) to carry out Treatment, Payment and Healthcare Operations (TPO).

Head to Toe Family Healthcare Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Head to Toe Family Healthcare reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Head to Toe Family Healthcare
735 N. 5th Street
Silsbee, TX 77656

With this consent, Head to Toe Family Healthcare may call my home or alternative 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 calls pertaining to my clinical care, including but not limited to laboratory tests.

With this consent, Head to Toe Family Healthcare may mail to my home or an alternative 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 CONFIDENTIAL".

With this consent, Head to Toe Family Healthcare may release my PHI to the family members or other persons that I have listed below:

1. _____ relationship_____
2. _____ relationship_____
3. _____ relationship_____

By signing this form, I am consenting to Head to Toe Family Healthcare 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, or later revoke it, Head to Toe Family Healthcare may decline to provide medical treatment to me.

Signature of Patient or Legal Guardian

____/____/____
Date

Printed Name of Patient or Legal Guardian

Patient's Name