Post Rock Family Medicine

Patient Consent for Use and Disclosure of Protected Health Information

Effective Date 4.14.2003, Updated 4.30.2012

Post Rock Family Medicine 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, Prairie Star Family Practice, PA, Rooks County Health Center Clinic and Solomon Valley Family Medicine, PA. This OHCA relates to clinic locations at 1210 North Washington, Suite B, Plainville, KS 67663; 107 South Spruce, 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 Post Rock Family Medicine (PRFM) to use and disclose my protected health information (PHI) to carry out treatment, payment, and health care operations (TPO). PRFM's Notice of Privacy Practices provides a more complete description of such uses and disclosures. By signing this form, I am consenting to PRFM'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. PRFM 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, Suite B, Plainville, KS 67663.

With this consent, PRFM 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, PRFM 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 PRFM restrict how it uses or discloses my PHI to carry out TPO. PRFM 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 PRFM. 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 PRFM has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, PRFM 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