Patient Consent for Use and Disclosure of Protected Health Information

(Gives the doctor permission to call or mail lab results, appointment time or other health information you, your family or other people you identify.)

With this consent, I give Dr. Jill Ritter permission to call and leave a message regarding my lab and biopsy results and appointment information to the following sources:

_____Mail to my home address
_____Alternative mailing address
_____E-mail _____

_____Home Phone
_____Cell Phone
_____Business/Work Phone

To discuss my case including diagnosis, medication and treatment only with those listed below:

Name_____Relationship to Patient_____Tel.#_____

Name_____Relationship to Patient_____Tel.#_____

By signing this form, I am consenting to this disclosure agreement and allow Dr. Jill Ritter to communicate my health information as I have outlined above.

_____Date:_____
Signature of Patient or Guardian

I hereby give my consent for Dr. Jill Ritter to use and disclose protected health information (PHI) about me to carry out treatment, payment and health operations (TPO). If you would like to read more information, the Notice of Privacy Practices that is provided on the registration clipboard provides a more complete description. I understand that if Dr. Jill Ritter feels that the information I provide threatens my well being, safety of myself or others, she is obligated to disclose the information to my emergency contact and/or close family member. I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Jill Ritter reserves the right to revise the Notice of Privacy Practices at any time. A revised copy may be obtained by writing a written request to Dr. Jill Ritter.