Effective date: 09/27/2023

PATIENT CONSENT FORM

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Rebecca A. Coats, MD to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO) as disclosed in the Notice of Privacy Practices provided by Rebecca A. Coats, MD.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Rebecca Coats, MD 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 Dr. Coats or in person.

With this consent, Dr. Coats and her representatives may call my home or other alternative, approved 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 laboratory test results, among others.

With this consent, Dr. Coats and her representatives may send mail to my home, email or mobile phone or other 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.”

I have the right to request that Dr. Coats and her representatives restrict how she/ they uses or discloses my PHI to carry out TPO.

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 allow Dr. Coats to use and disclose 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.

The above statements are not guaranteed to be true if I do not sign this consent.

Dr. Coats may refuse service should it be determined appropriate medical care cannot be provided in the absence of said consent, such as in the care of a minor, spouse, family member or other health care designee or in the case of power of medical authority.

Signed by,

_____

Printed name of patient and/or guardian or representative

_____

Signature of patient and/or guardian or representative Date

_____

Relationship to patient if signed by guardian or representative

Use of this form is optional and not required under the HIPAA privacy rule.