

PATIENT HIPAA LAW AWARENESS

Please read and sign: HIPAA laws protect patient's privacy

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Paul Jarrod Frank reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

In accordance with HIPAA privacy laws, I am aware that patient information may be disclosed only in order to facilitate patient care. With my permission, Dr. Paul Jarrod Frank may use and disclose **protected health information (PHI)** about me to carry out **treatment, payment and healthcare operations (TPO)**. Please refer to Dr. Paul Jarrod Frank's Notice of Privacy Practices for a more complete description of such uses and disclosures.

With my permission, the office of Dr. Paul Jarrod Frank may call my home or other designated locations 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 permission, the office of Dr. Paul Jarrod Frank may mail to my home, email, or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Dr. Paul Jarrod Frank restrict how it uses or discloses my PHI to carry out TPO. However, if it does, it is bound by this agreement.

By signing this consent, I am allowing Dr. Paul Jarrod Frank to use and disclose my **protected health information (PHI)** to carry out my **treatment, payment, and healthcare operations (TPO)**. I understand that this consent agreement is for my protection so that my information is kept confidential.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Signature of Patient or Legal Guardian

Print Name of Patient or Legal Guardian

Date