



HIPAA CONSENT

Consent to Use or Disclose Information for Treatment, Payment or Health Care Operations

I understand that Clermont Medical Center, PA may use and disclose my protected health information (PHI) to carry out treatment, payment and health care operations (TPO) as described in the Notice of Privacy Practices.

Treatment includes coordination of care with other health care providers; payment includes activities needed to obtain reimbursement for services; and health care operations include activities such as quality assessment, training and administrative functions.

I acknowledge that I have been provided access to the Notice of Privacy Practices and may request a paper copy at any time.

I understand that I may revoke this consent in writing, except to the extent that action has already been taken in reliance on this consent or as otherwise permitted or required by law.

PATIENT INFORMATION

Patient Full Name (Please Print)

Date of Birth

Medical Record Number (if known)

COMMUNICATION PREFERENCES

- ☐ You may leave appointment reminders or necessary health/payment information by voicemail, text, email, or with family.
- ☐ Do NOT leave a message on my answering machine or with a family member.
- ☐ Do NOT leave a message on mobile voicemail, text message, or email.
- ☐ You may send my healthcare information by unsecured email; I understand email may be accessible by others.

SIGNATURE

By signing below, I acknowledge that I have read and understand this consent and my communication preferences.

Patient Signature

Date

If signing for patient (parent, guardian, or legally authorized representative):
Printed Name

Relationship to Patient