Macomb Orthopedics

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Macomb Orthopedics** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

My “protected health information” (PHI) means health information, including my demographic information collected from me or received by my physician from another healthcare provider, my employer, or a healthcare clearing house.

(The Notice of Privacy Practices provided by Macomb Orthopedics describes such uses and disclosures more completely.)

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

With this consent, **Macomb Orthopedics** may call my home or other alternative 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.

By signing this form, I am consenting to allow **Macomb Orthopedics** 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. If I do not sign this consent, or later revoke it, **Macomb Orthopedics** may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

______________________________ ______________________
Print Patient’s Name Date

____
Print Name of Patient or Legal Guardian, if applicable