Careteam+®
FAMILY HEALTH & SPECIALTY CARE

Consent to the Use and Disclosure of Health Information

I understand that as part of my healthcare, Careteam+, Inc. originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party can verify that services billed were actually provided and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a HIPAA Notice of Privacy Practices that provides a more complete description of the uses and disclosures. I understand that I have the right to review the notice prior to using this consent. I understand that the organization reserves the right to change its notice and practices and make provisions effective for all protected health information that it maintains. In the event that a revision is made, it will be communicated by providing the revised Notice upon request, posting the revised Notice in the office, and having a copy available for individuals to take with them. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken actions in reliance thereon.

Consent for Treatment and Release of Protected Health Information

I voluntarily consent to authorize the physicians, Non-Physician Practitioners, and staff of Careteam+ to provide healthcare services to me. No guarantees have been made to me about the results of treatment or healthcare services. I consent to the use and disclosure of my protected health information for the purposes of treatment, payment, and healthcare operations. I have read this form and have had the opportunity to ask question.

Authorization to Obtain Medication History

I authorize Careteam+ to obtain medication history, including those prescribed by other providers, for the purposes of continued treatment.

Financial Responsibility and Assignment of Benefits

I authorize Careteam+ to bill my insurance company using the information that I have provided for payment to Careteam+. I authorize payment of insurance benefits to be paid directly to Careteam+.

Printed Patient Name: _____

_____ _____ _____

Signature of Patient or Legal Representative **Signature of witness** **Date**

Please indicate any restrictions to the use of disclosure of my health information below:

Careteam+ has permission to discuss my medical care and treatment to the following person(s):

Name: _____ ***Relationship:*** _____

Careteam+ has permission to leave voicemail reminders (Y) ☐ (N) ☐ Ph: _____

Careteam+ has permission to send text reminders (Y) ☐ (N) ☐ Ph: _____

Careteam+ has permission to contact me at work (Y) ☐ (N) ☐ Ph: _____

Careteam+ has permission to contact me via email (Y) ☐ (N) ☐ Email: _____