CAPE FEAR
SPORTS MEDICINE

Patient Consent for use and Disclosure
Of Protected Health Information

I understand that Cape Fear Sports Medicine, P.A. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluation the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Cape Fear Sports Medicine, P.A. will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restriction.

I herby consent to the use and disclosure of my personal health information for purposes as noted in Cape Fear Sports Medicine, P.A. Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time. I am authorizing the personnel at Cape Fear Sports Medicine, PA to leave information related to my medical care with others if I am not available.

Patient Name (Please Print) _____

DO WE HAVE PERMISSION TO:

Leave a message on your home answering machine? [ ] YES [ ] NO

Leave a message on your cell phone? [ ] YES [ ] NO

Leave a message at your place of employment? [ ] YES [ ] NO

With whom may we discuss your health information (diagnosis, treatment plan, appointment times, billing)?
please list:

_____
_____
_____
_____

Email you? [ ] YES [ ] NO Email address_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES; WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Cape Fear Sports Medicine, PA privacy policy. The policy provides in detail the uses and disclosures of my protected health information (PHI).

_____ _____
Signature of Patient or Legal Guardian Date

_____
Relationship to Patient (if Legal Guardian)