Restoration Health

CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

I AUTHORIZE Restoration Health to perform medical treatment.

I CONSENT to Restoration Health's use and disclosure of all individually identifiable personal, health, financial, and demographic information (known as Protected Health Information or PHI) for the purposes of:

- Providing medical treatment
- Obtaining payment and reimbursement
- Obtaining authorizations from my insurance
- Requesting healthcare services from other providers
- Cooperating with other providers in my medical treatment
- Fulfilling requests for information when specifically authorized by me
- In addition, doing all other things directly related to providing healthcare to me (messages, reminders)

The above purposes and all other uses are known collectively as Treatment, Payment and Other Healthcare Operations or TPO and this information may include or be related to psychiatric or psychosocial impairments, substance abuse, human immunodeficiency virus (HIV), HIV-related opportunistic infection, or pregnancy. You may review or receive a copy of our entire Notice of Privacy Practices upon request.

I AUTHORIZE any physician or healthcare facility to provide upon request any PHI to Restoration Health when needed for the purpose of TPO.

I CONSENT to Restoration Health discussing any or all of my medical care including my evaluation, treatment, diagnosis even if related to psychiatric or psychosocial impairments, substance abuse, human immunodeficiency virus (HIV), HIV-related opportunistic infections, or pregnancy with the following personal contact(s).

1. _____Relationship:_____ Phone Number:_____
2. _____Relationship:_____ Phone Number:_____
3. _____Relationship:_____ Phone Number:_____

I have been given the opportunity to review and agree with the terms and conditions of Restoration Health's Patient Information Protection Plan.

I understand my rights to restrict the use and disclosure of PHI and to revoke this consent at any time in writing.

I understand that should I choose not to consent to the terms and conditions of Restoration Health's Patient Information Protection Plan, the practice has the right to and will withhold treatment except where required by law.

PATIENT NAME (please print)_____

PATIENT'S SIGNATURE_____DATE:_____

GUARDIAN'S SIGNATURE_____DATE:_____

The Health Insurance Portability and Accountability Act of 1996 prohibits the use and disclosure of protective health information for treatment, payment, and other healthcare operations without a signed consent and prohibits the use and disclosure of protective health information for non healthcare related activities without specific and explicit authorization.

_____By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach & messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, missed appointment, overdue wellness visit, or any other reasonable healthcare related communication. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information regarding healthcare events, unpaid balances, missed appointments, and to leave a reminder message on my voicemail or answering system if I am unavailable at the number provided by me.