☐ **Owensboro Heart & Vascular**
☐ **Owensboro Primary Care**
☐ **Immediate Care Center**
☐ **Owensboro Advanced Sleep Center**
☐ **Owensboro Medical Practice Laboratory**
☐ **Rejuve Medical Spa**
☐ **Research Integrity**
☐ **The McLean Clinic**
☐ **The Muhlenberg Clinic**

DATE: _____

MRN#: _____

PRIVACY CONSENT FORM FOR DISCLOSURE OF PATIENT INFORMATION FOR THE PURPOSES OF TREATMENT AND PAYMENT

Initial

_____ **Payment:** I authorize Owensboro Medical Practice, PLLC (OMP) to submit claims on my behalf directly to Medicare / Medicaid / my private health insurance carrier. This means that OMP will direct payment for supplies and services provided. I understand that I am financially responsible to OMP for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims.

_____ **Consent for Treatment:** I authorize OMP to administer treatments, tests and/or diagnostic tests to treat me/the patient's injury/illness. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, as part of the care to be given, a test may be performed for human immunodeficiency virus infection (HIV/AIDS), hepatitis, or other blood-borne infectious or communicable diseases if the Physician, APRN, or Physician Assistant orders the test for diagnostic purposes because of my/the patient's medical history, symptoms or conditions.

_____ **Consent for Privacy:** I authorize OMP using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity.

_____ **Specific Records Expressly Included:** Expressly authorize release of the following information for the purposes of treatment, payment and health care operations, if it is part of my protected health information (CHECK ANY OR ALL YOU AGREE TO AUTHORIZE FOR RELEASE):

☐ Chemical Dependency/Substance Abuse
- •Drugs
- •Alcohol

☐ Sexually Transmitted Diseases

_____ **Quality:** I authorize OMP the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

_____ **Research**: I authorize OMP the disclosure of my protected health information for research purposes, if certain conditions are met.

_____ **Electronic Prescription**: I authorize OMP to utilize electronic prescribing technology and participate with SureScript. SureScripts operates the Pharmacy Health Information Exchange, which facilitates the electronic transmission of prescription information between providers and pharmacists. SureScripts also provides prescription data on any medications, known as medication history, which are prescribed to me/the patient.

_____ **Cell Phone Calls/Text and Emails:** As a service to our patients, we provide courtesy appointment reminder calls/texts and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls/texts at this number. By providing your email address you acknowledge that you may receive health care surveys and other health care related communications. You understand this is not to be used for provider communication and that email is not secure and can be intercepted and used by unauthorized persons.

I further acknowledge Owensboro Medical Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

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OWENSBORO
Medical Practice

DATE: _____

MRN#: _____

Involvement of Others in Care: I authorize OMP to provide and discuss my/the patient's care and medical needs with the following persons:

Name	Date of Birth	Relationship	Phone

Patient Rights and Responsibilities:
I acknowledge receipt of the Patient Rights and Responsibilities _____ Declined_____

Notice of Privacy Practices:
I acknowledge receipt of the Notice of Privacy Practices _____ Declined_____

Minor Patient Photograph:
I consent for OMP to photograph the patient for identification purposes only_____ Declined_____

_____ _____
Patient/Parent/Legal Guardian/Legal Authorized Representative Signature **Date**

If Parent/Legal Guardian/Legal Authorized Representative, Print Name _____