BluMine HEALTH

I. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You May Refuse to Sign this Section: Receipt of Notice of Privacy Practices)

I have received a copy of this office's Notice of Privacy Practices.

Patient Name: _____ **Date of Birth**: _____**Age:** _____
(First, Middle Initial, Last Name)

X **Signature:** _____ **Date:** _____
Patient/Parent/Legal Guardian

_____ **Relationship to Minor**: _____
If Patient is a Minor, print name of Parent/Guardian

II. CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

(Refusal to sign this Consent for Use and Disclosure will result in non-treatment)

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health Information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, by contacting our office.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to this office. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE OF CONSENT I HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THE CONTENTS OF THIS Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

X Signature: _____ Date: _____ Relationship to Patient: _____

III. AUTHORIZATION TO RELEASE PATIENT RECORD INFORMATION

(Refusal to sign this Authorization to Release Patient Record will result in non-treatment)

To whom may we talk to about your medical treatment?

In addition to the authorization for release of my personal PHI described in Section I and II of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment, and prognosis to the following individual(s):

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship:_____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

If any of the above information changes, it is the patient/parent/legal guardian's responsibility to contact our office.

Patient Name: _____ **Date of Birth**: _____

Consent to e-mail or text usage for appointment reminders and other healthcare communications:

Patients in our practice may be contacted via e-mail and/or text messaging to remind you of an appointment, labs, RX, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time you provide an e-mail or text address at which you may be contacted, you consent to receiving appointment reminders and other healthcare communications/information at that e-mail or text address from our practice.

I authorize my provider and his/her staff to leave detailed messages regarding the above medical information on the following answering machine/voice mail or e-mail:

- ☐ Home Phone _____
- ☐ Work Phone _____
- ☐ Cell/Mobile Phone _____
- ☐ E-mail: _____

If any of the above information changes, it is the patient/parent/legal guardian's responsibility to contact our office.

X Signature: _____ Date: _____ Relationship to Patient: _____
Patient/Parent/Legal Guardian

IV. MISCELLANEOUS

If the patient is a minor child (under 18), please list any individuals who may bring your child to their appointment in your absence:

Print Name: _____ Relationship to Patient: _____
Print Name: _____ Relationship to Patient: _____
Print Name: _____ Relationship to Patient: _____

Loss of Personal Articles:

I understand that BluMine Health is not liable for the loss of or damage to money, jewelry, glasses, dentures, documents, clothing or other items of personal property.

Smoke-Free Environment:

BluMine Health maintains a smoke-free environment. Smoking is prohibited by health care personnel, patients, and visitors except in designated areas outside the building.

X Signature: _____ Date: _____ Relationship to Patient: _____
Patient/Parent/Legal Guardian

YOU ARE ENTITLED TO A COPY OF THIS DOCUMENT AFTER YOU SIGN IT

FOR BluMine OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

_____ Individual refused to sign _____ Emergency situation prevented us from obtaining acknowledgement
_____ Communication barriers prohibited obtaining acknowledgement _____ Other (Please Specify) _____