ALGONE DFW
INTERVENTIONAL PAIN
5860 Collin McKinney Parkway, Suite 604, McKinney, TX 75070

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Algone Anchorage to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Algone Anchorage describes such uses and disclosures more completely.) I have the right to review the Notice of Privacy Practices prior to signing this consent. Algone Anchorage reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Algone DFW Interventional Pain Clinic
5860 Collin McKinney Parkway, Suite 604,
McKinney, TX 75070

With this consent, Algone Anchorage may call my home or other alternative location and leave a message on voice mail if needed (unless a Refusal to Voicemail form is completed) or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Algone Anchorage may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential.”

With this consent, Algone Anchorage may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Algone Anchorage restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement

By signing this form, I am consenting to allow Algone Anchorage to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it Algone Anchorage may decline to provide treatment to me.

Print Patient Name:

Legal Guardian's Name (if applicable):

_____ _____

Patient or Parent/Guardian Signature Date