Consent for Disclosure of Health Information (To Third Parties) & Consent by Proxy for Non-Urgent Care

Patient Name: _____ **DOB:** _____ **SSN:** _____ **Sex:** _____

TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you are, where indicated, consenting to the use and disclosure of the your protected health information to the assigned person(s) below to carry out necessary treatment, payment activities, and healthcare operations which includes other healthcare professionals directly related to your treatment and insurance companies. Further, you are, where indicated, appointing the assigned person(s) below as a proxy decision-maker(s) for consenting to non-urgent medical care for you.

Right to Revoke: You have the right to revoke this Consent at any time by submitting written notice of your revocation to the Medical Records Department. Revocation of this Consent will not affect any action we have taken regarding this Consent before we received your revocation. This consent is valid and remains in effect as long as you are a patient of HealthPOiNT, until you withdraw your consent, or until HealthPOiNT changes its services and asks you to complete a new consent form.

THIRD PARTY/PROXY INFORMATION*

1. Name: _____ Relationship to Patient: _____

   Driver's License #: _____ State: _____ Phone Number: _____

   Address: _____

   ☐ Access to patient's information regarding treatment or account status ☐ Proxy decision-maker for patient's non-urgent care

2. Name: _____ Relationship to Patient: _____

   Driver's License #: _____ State: _____ Phone Number: _____

   Address: _____

   ☐ Access to patient's information regarding treatment or account status ☐ Proxy decision-maker for patient's non-urgent care

3. Name: _____ Relationship to Patient: _____

   Driver's License #: _____ State: _____ Phone Number: _____

   Address: _____

   ☐ Access to patient's information regarding treatment or account status ☐ Proxy decision-maker for patient's non-urgent care

LIMITATIONS

Identify any limitations on the kinds of health information or medical services for which this consent is given. If none, state "none".

_____

Identify any limitations on the time frame for which this consent is given. If none, state "none".

_____

ACKNOWLEDGMENT & SIGNATURE

I have read and considered the contents of this Consent form. I understand that, by signing this Consent form, I am giving my consent to HealthPOiNT to disclose my protected health information in order to carry out treatment, payment activities, and healthcare operations, and/or allow a proxy decision-maker(s) to consent for my non-urgent medical care, as indicated.

Patient/Legal Representative Signature: _____ Date: _____

Legal Representative's Name: _____ Relationship to Patient: _____

*Individuals must present themselves with two forms of identification