COMPREHENSIVE BREAST CARE OF DENVER

1960 Ogden Street #230
Denver, CO 80218
T:303.318.3580 F:303.318.2483

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I consent to the use or disclosure of my protected health information by Comprehensive Breast Care of Denver herein known as “Health Care Provider”, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of “Health Care Provider”.

I understand that diagnosis or treatment of me by “Health Care Provider” may be conditioned upon my consent as evidenced by signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. “Health Care Provider” is not required to agree to the restrictions that I may request. However, if “Health Care Provider” agrees to a restriction that I request, the restriction is binding on “Health Care Provider's” Practice.

I have the right to revoke this consent, in writing, at any time, except to the extent that “Health Care Provider” has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review “Health Care Provider's” Notice of Privacy Practices prior to signing this document.

The “Health Care Provider's” Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of “Health Care Provider.

The Notice of Privacy Practices for “Health Care Provider” is also provided at the Reception Area and on the “Health Care Provider's” web site at www.oasd.net.

This Notice of Privacy Practices also describes my rights and the duties of “Health Care Provider” with respect to my protected health information.

“Health Care Provider” reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.I may obtain a revised Notice of Privacy Practices by accessing the “Health Care Provider's” Web site, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____ _____
Printed Name of Patient Signature of Patient Date

_____
Maiden/Previous Name

If signed by someone other than patient, indicate relationship and reason:

_____

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NOTICE: PATIENT PRIVACY Effective Date_____

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We are required by law to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The effective date at the top right hand side of this page indicates the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet received a copy of our most current Notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact our office at 303-318-3413.

_____ _____ _____
Printed Name of Patient Signature of Patient Date

_____
Maiden/Previous Name

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_____

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REQUEST FOR RESTRICTION ON USE AND DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION

Patient Name: _____

Home Phone: _____

Cell Phone: _____

Address: _____

City: _____

State: _____

Zip: _____

1) Medical Information to be Restricted:

2) Nature of Restriction:

3)Medical Information to be Communicated Confidentially:

4)Alternative Location/Address/Telephone Number/E-mail:

To our patients: You have the right to request that we restrict our use and disclosure of your medical records and information. We do not have to agree to your requested restrictions. If we do agree to the requested restriction, we will abide by the restriction unless a medical emergency requires otherwise. You also have the right to request that we communicate certain medical information to you in confidence. We will accommodate your reasonable written requests to receive communications of medical information by alternative means or at alternative locations only if you (1) specify the alternative location, address, or telephone number and/or the alternative means of contact and (2) agree to be responsible for and explain how payment will be handled for any additional costs associated with the alternative method of communication. By your signature below, you acknowledge that you understand and agree to the above information.

_____ _____ _____
Printed Name of Patient Signature of Patient Date

_____
Maiden/Previous Name

If signed by someone other than patient, indicate relationship and reason:

_____

Request for restriction Accepted _____
Request for Restriction Denied _____
Request to Communicate Confidentially Accepted _____
Request to Communicate Confidentially Denied _____