HARRISON HEALTH PARTNERS

Patient Opt-Out Consent Form

I agree to permit the practice to request and obtain previous medical records from or forward records to other providers if deemed necessary to provide me with proper care and treatments.

I agree to the release of all my insurance and medical information to other health care providers, my insurance company, Medicare or any third party payer to facilitate health care, processing of claims and audit of payments. I understand that the information released may need to include records regarding HIV/AIDS, sexually transmitted diseases, mental health and drug and alcohol abuse treatment health information

I agree to be contacted for routine appointments or follow-up information regarding my care by:

- Phone..... _____ Initials
- Answering Machine..... _____ Initials
- Mailed appointment card reminders..... _____ Initials

I agree to allow the practice to use and disclose information regarding my care as needed:
(Choose one)

- Without restrictions/limits to family and friends..... _____ Initials
- Restricted/limited to the family and friends listed below..... _____ Initials

PLEASE LIST THE INDIVIDUALS **YOU WISH** TO PARTICIPATE IN YOUR CARE:
The individuals listed here will be considered the **only** individuals you wish for us to communicate with regarding your care. (If these individuals are **not** available in an emergent situation we may need to use our discretion regarding use and disclosure of your medical information.)

_____
Name of Individual Phone Number

_____
Name of Individual Phone Number

PLEASE LIST (IF ANY) INDIVIDUALS **YOU DO NOT WISH** TO PARTICPATE IN YOUR CARE:

_____
Name of Individual

_____
Name of Individual

I agree to be contacted regarding treatment options and health-related benefits regarding medical options that may improve my quality of life..... _____ Initials

I understand that I am financially responsible for any and all charges my insurance does not pay. I also agree to pay any finance charges or collection fees that should arise from nonpayment.

These consents will remain in effect until revoked by me in writing.

_____
Signature of patient or legally authorized individual Date