The Bauman Clinic

Margaret K. Bauman, MD

Adult and Child Psychiatry

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **The Bauman Clinic** 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 **The Bauman Clinic** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **The Bauman Clinic** 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 **The Bauman Clinic.**

With this consent, **The Bauman Clinic** may call my home or other alternative location and leave a message on voice mail 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, **The Bauman Clinic** 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, **The Bauman Clinic** 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 **The Bauman Clinic** 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 **The Bauman Clinic** 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, **The Bauman Clinic** may decline to provide treatment to me.

* If patient is a minor, signature may be required, depending on state law.

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Patient Consent for Use and Disclosure of Protected Health Information

Signature of Patient	Date Signed
Signature of Parent, Legal Guardian or Conservator	Date Signed
Signature of Witness (if appropriate)	Date Signed