TEXAS SPORTS MEDICINE AND ORTHOPAEDIC GROUP (T.S.M.O.G.)

UNIVERSITY PARK *LAS COLINAS* *FRISCO*

PATIENT CONSENT FORM FOR H.I.P.A.A.

I understand that as part of my healthcare, **T.S.M.O.G.** originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

T.S.M.O.G.'s Privacy Notice provides specific information and complete description of how my personal information may be used and disclosed. I have been provided a copy of or access to the Privacy Notice and understand that I have the right to review the notice prior to signing this consent. I understand that **T.S.M.O.G**. reserves the right to change the Privacy Notice. Prior to implementation of the revised Privacy Notice, the revised will be mailed to me if I provide my address below. I understand that I have the right to restrict the use and/or disclosure of my personal health information (PHI) or treatment, payment or healthcare operations and that **T.S.M.O.G**. is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that **T.S.M.O.G.** has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

I give my consent for **T.S.M.O.G.** to discuss my personal health information to the people or facilities I have listed below.

Name	Relation to Patient	Phone #	Type
			☐ Hm ☐ Wk ☐ Cell
			☐ Hm ☐ Wk ☐ Cell
			☐ Hm ☐ Wk ☐ Cell

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been provided and have reviewed **T.S.M.O.G.'S** *Notice of Privacy Practices* _____
Please initial

_____
Print Name of Patient

_____ _____
Signature of Patient or Legal Representative Date

_____
Print Name of Legal Representative

I request that any changes to the *Notice of Privacy Practices* be sent to me at the address below:

_____

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