CONSENT FOR TELEHEALTH TREATMENT

PATIENT NAME: _____ **DATE OF BIRTH:** _____

I, _____, authorize and direct the physicians and medical staff for telehealth to render medical care as determined necessary at the time of service.

_____ _____

Patient Signature Date

If patient is a minor or unable to sign:

_____ _____

Name of Person Giving Consent on behalf of patient Relationship to Patient

_____

Signature of person signing on behalf of patient

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Association for Improving Medical Accessibility to use and disclose protected health (PHI) about me to carry out treatment, payment and health care operations. (The Notice of Privacy Practices provided by Association for Improving Medical Accessibility describes such uses and disclosures more completely and is continually posted on the wall in the waiting room at Association for Improving Medical Accessibility along with a HIPPA Patient Manual.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Association for Improving Medical Accessibility 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 Association for Improving Medical Accessibility.

With this consent, Association for Improving Medical Accessibility 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 TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Association for Improving Medical Accessibility may mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements."

With this consent, Association for Improving Medical Accessibility may e-mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements. I have the right to request that Association for Improving Medical Accessibility restrict how it uses or discloses my PHI to carry out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. 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 Association for Improving Medical Accessibility to use and disclose my PHI to carry out treatment, payment, and health care operations.

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, Association for Improving Medical Accessibility may decline to provide treatment to me.

_____ _____ _____

Patient Signature or Legal Guardian Date Relation to Patient

_____ _____

Print Patient's Name Print Name of Legal Guardian