Patient Consent for Confidential Communication Regarding Protected Health Information

This is my consent for Premier Medical, LLC (dba Premier Wound Care and ID Specialist), and Scott D. Parker MD, LLC to use and disclose my protected health information to carry out treatment, payment, and healthcare operations. This is my acknowledgement that I may view Premier Medical, LLC and Scott D. Parker MD, LLC Notice of Privacy Practices.

This is my consent for Premier Medical, LLC, dba Premier Wound Care and ID Specialist, and Scott D. Parker MD LLC to: (please initial approval)

_____Call my home and leave a message on voicemail or in person to remind me of appointments, or obtain insurance information.
_____Text my mobile phone with appointment reminders
_____Call and leave reports of my clinical care; lab results.
_____Mail items that assist in carrying out my treatment, payment, or health operations, such as Appointment reminder card and patient statements to:
_____my home
_____other designated location:_____

This is my consent for information regarding my general health and treatment to be discussed with the following people in the event that I am unavailable or in case of an emergency.

_____

_____

_____

By signing this form, I am consenting to Premier Medical, LLC, dba Premier Wound Care and ID Specialist, and Scott D. Parker MD LLC's use and disclosure of my protected health information to carry out treatment, payment, and healthcare operations. I understand that I will be responsible for any collection fees for unpaid account balances. I may revoke my consent in writing except on those disclosures made prior to my consent. I understand that Premier Wound Care and ID Specialist and Scott D. Parker MD LLC reserve the right to refuse to treat me if I do not sign this consent form.

_____ _____
Patient's Name Date

_____ _____
Signature of Patient or Legal Guardian If Legal Guardian signed, Print Name Here

_____ _____
Witness Date