Apollo Healthcare Associates LLC
General Consent for Treatment, Evaluation and Information Release

Patient Name: _____ **Date of Birth: _____**

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Initial

Notice of Privacy Practices. I acknowledge that I have reviewed the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact Apollo Healthcare Associates if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

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Initial

Release of Information. I hereby permit Apollo Healthcare Associates LLC to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information may be made available to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations.

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Initial

Consent to Treatment. I consent to evaluation and/or treatment that Apollo Healthcare Associates may deem necessary in the judgement of my health care provider. This may include, but is not limited to diagnostic, radiology, laboratory examinations and procedures, medical treatment and procedures, and medication administration. I understand that I have the right to refuse consent to any proposed procedure or treatment at any time prior to its performance.

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Initial

Consent for Photographing or Other Recording for Security and/or Health Care Operations: I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

_____ I hereby authorize that Apollo Healthcare Associates may leave messages at the phone numbers indicated below .
Initial

Number

- □ Home Phone Answering Machine or Voice Mail: _____
- □ Cell Phone Voice Mail: _____
- □ Cell Phone Text Message: _____
- □ Other Phone Voice Mail: _____

_____ I hereby authorize that Apollo Healthcare Associates may contact me at the following email address:
Initial

Email Address: _____

_____ I hereby authorize that Apollo Healthcare Associates may leave messages with other members of my household
Initial regarding my appointments or requests for me to contact the office.

_____ I hereby authorize that Apollo Healthcare Associates may disclose my health information to any person(s) who
Initial accompany me to my appointment, and are present with me in the clinic while I meet with my healthcare provider(s).

_____ I hereby authorize that Apollo Healthcare Associates may disclose my personal health information to the person
Initial who I have listed as my emergency contact.

Emergency Contact: _____ Phone Number: _____

_____ I hereby authorize that Apollo Healthcare Associates may disclose my personal health information for the
Initial purposes of communicating results, findings, and care decisions to the following persons listed below:

Name	Telephone Number	Relationship to Patient

Patient may revoke or modify this specific authorization and that revocation or modification must be in writing.

_____ _____ _____ _____
Name of Patient Date Name of Authorized Representative Date

_____ _____ _____ _____
Signature of Patient Date Signature of Authorized Representative Date

Updated January 5, 2016