
Name of Patient (Print)

HIPPA

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by New Hope Orthopaedics and Sports Medicine for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of New Hope Orthopaedics and Sports Medicine. I understand that diagnosis or treatment of me by Norman Mindrebo, M.D., Sara Hannon PA-C or Vicki Stebbins PA-C may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. New Hope Orthopaedics and Sports Medicine is not required to agree to the restrictions that I may request. However, if New Hope Orthopaedics and Sports Medicine agrees to a restriction that I request, the restriction is binding on New Hope Orthopaedics and Sports Medicine and Norman Mindrebo, M.D., Sara Hannon PA-C or Vicki Stebbins PA-C.

I have the right to revoke this consent, in writing, at any time, except to the extent that Norman Mindrebo, M.D., Sara Hannon PA-C, Vicki Stebbins PA-C or New Hope Orthopaedics and Sports Medicine has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review New Hope Orthopaedics and Sports Medicine's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the New Hope Orthopaedics and Sports Medicine.

New Hope Orthopaedics and Sports Medicine reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the New Hope Orthopaedics and Sports Medicine's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient Signature

Date

Guardian Signature (If Patient is Under 18 years old)

Access to Private Health Information (PHI)

I _____ authorize the staff of New Hope Orthopaedics to

Release PHI to the following family members/friends _____.

I authorize New Hope Orthopaedics Staff to leave PHI concerning me on voicemail at the following

Telephone number _____.

By signing my name below, I grant this authorization to access my PHI until it is revoked in writing by me.

Patient Signature

Date