# NORTH TEXAS INFECTIOUS DISEASES CONSULTANTS, PA

**Patient Consent for Use and Disclosure of Protected Health Information**

With my consent, North Texas Infectious Diseases Consultants, PA, (NTIDC) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to NTIDC's Notice of Privacy Practice for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Procedures prior to signing the consent. NTIDC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the NTIDC Privacy Officer at 3409 Worth St., Sammons Tower, Suite 710, Dallas, Texas, 75246.

With my consent, NTIDC may call and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

**Phone #** _____N/A__ **Fax #** _____N/A__ **Initials** _____

With my consent, NTIDC may mail to my home or other designated location any items that assist in carrying out TPO, such as information letters and patient statements as long as they are marked Personal and Confidential.

**Address:** _____ **Initials** _____

_____ N/A _____

With my consent you may disclose protected health information (PHI) about me to the following people:

_____ **Initials** _____

_____ N/A _____

***With my consent, NTIDC may contact me regarding a possible research study. Initials _____***

With my consent, NTIDC may email me, any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that NTIDC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

**Email Address:** _____N/A_____ **Initials** _____

**Referring Physician**: _____ Phone **number**_____

**Emergency Contact**: _____**Phone**: _____

**Address**: _____

By signing this form, I consent to NTIDC's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance up prior consent.

_____ _____

Print Patient's Name Date of Birth Patient's Signature Date

_____ _____

Signature of Patient's Legal Guardian Print Name of Patient's Legal Guardian