TransSouth HEALTH CARE

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PATIENT CONSENT FOR RELEASE OF INFORMATION

Please Print Legibly & Complete All Information

This form is required by the federal government.

I, _____, hereby authorize TransSouth Healthcare to disclose my health information, which specifically identifies me, or which can reasonably be used to identify me, to carry out my treatment, payment, and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, **TransSouth Healthcare** can refuse to treat me.

I have been informed that **TransSouth Healthcare** has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment, and health care operations. I have the right to obtain a paper copy upon request.

I understand that I may revoke this consent at any time by notifying **TransSouth Healthcare** in writing, but if I revoke my consent, such revocation will not affect any actions that **TransSouth Healthcare** took before receiving my revocation.

I understand that **TransSouth Healthcare** has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that **TransSouth Healthcare** restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment, or health care operations. I understand that **TransSouth Healthcare** does not have to agree to such restrictions, but that once such restrictions are agreed to, **TransSouth Healthcare** must adhere to such restrictions.

I acknowledge and agree that **TransSouth Healthcare** and any affiliate or vendor thereof, including collection or billing companies, may contact me by telephone or text message to any phone number I have provided to you, and any other phone number associated with my account, including wireless or mobile phone numbers. I further agree that you may use any method of contact to these numbers provided, such as an Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify **TransSouth Healthcare** if I have given up ownership or control of any such telephone number.

HIPAA Privacy Notice / Patient Rights / Advanced Directive

I hereby acknowledge that a copy of the Notice of Privacy Practices for **TransSouth Healthcare** has been made available to me. I have the right to obtain a paper copy upon request.

I have received written and verbal notification regarding my patient rights prior to my procedure. I have also received information regarding **TransSouth Healthcare** policies pertaining to advanced directives. Advanced Directives will not be honored within this office.

_____ _____ _____

Signature of Patient or Patient Representative *Date of Birth* *Date*

_____ _____

Print Name of Patient or Patient Representative *Relationship to Patient*

RELEASE OF MEDICAL & BILLING INFORMATION

I, _____, authorize the physicians and staff of TransSouth Healthcare to release information on file regarding my medical treatment and billing account to the person(s) listed below:

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

I understand that by signing this release, the designated person(s) above will be able to speak to any member of the medical staff. Furthermore, I understand that these medical practices cannot be held liable for any information the above stated person(s) may obtain regarding my medical and billing information.

_____ _____

Signature of Patient or Patient Representative *Date*

_____ _____

Signature of Witness *Date*

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TO EXPEDITE VISIT: Print form, fill out prior to visit, and bring to your appointment. Thank you!

REFERRING MD: _____

PRIMARY CARE PROVIDER: _____

NAME (First, MI, Last): _____

BIRTHDATE: _____/_____/_____ SOCIAL SECURITY #: _____-_____-_____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ COUNTY: _____

HOME PHONE: (_____)_____-_____

CELL PHONE: (_____)_____-_____

EMAIL: _____

Do you prefer to be contacted by:
- ☐ Cell
- ☐ Home
- ☐ Email
- ☐ No Preference

PHARMACY: _____ CITY: _____

EMPLOYER: _____ PHONE: (_____)_____-_____

RACE: _____ ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐ Other

EMERGENCY CONTACT

NAME: _____

PHONE: (_____)_____-_____ RELATIONSHIP: _____

Do you want to be reminded of appointments by:
- ☐ Cell Phone Call
- ☐ Cell Phone Text
- ☐ Email
- ☐ No Preference

SIGNATURE: _____ DATE: _____