Rockford Neuroscience Center

Patient Consent for Use and Disclosure Of Protected Health Information

With my consent, Rockford Neuroscience Center, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

I have the right to review the Notice of Privacy Practice prior to signing this consent. Rockford Neuroscience Center reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to Rockford Neuroscience Center Privacy Office at 4920 East State Street, Rockford, IL 61108.

With my consent, Rockford Neuroscience Center may call my home or other designated location 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 clinical care, including laboratory results among others.

With my consent, Rockford Neuroscience Center, may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patients statements.

With my consent, Rockford Neuroscience Center, may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Rockford Neuroscience Center 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.

By signing this form, I am consenting to Rockford Neuroscience Center use and disclosure of my PHI to carry out this TPO.

If I do sign this consent, I understand there is no expiration date and to revoke my consent, I will do this in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

If I do not sign this consent, _____ may decline to provide treatment to me.
Doctor

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date