im HEALTH

372 West Lancaster Ave
Wayne, PA 19087

## ACKNOWLEDGEMENT OF NOTIFICATION OF PRIVACY PRACTICES

I, _____ DOB:_____, acknowledge that I have been notified of this practice's privacy policy that includes medical and prescription history, and a written copy of this policy has been made available to me.

_____ _____

Patient's Signature Date

## CONSENT TO RELEASE MEDICAL INFORMATION

I, hereby authorize the disclosure of my protected health information (including but not limited to results, prescriptions, and appointment) to the person(s) listed below.

Name: _____ Relationship_____

Name: _____ Relationship_____

Name: _____ Relationship_____

I hereby authorize the practice to leave health information and appointment reminders on

**Phone Number:** _____ Home/Cell/Work

☐ I allow IM Health to leave messages on this phone number.

☐ I allow IM Health to text this phone number.

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## Patient Consent for Treatment and for Use and Disclosure of Protected Health Information

I authorize medical treatment as deemed necessary and appropriate by the medical providers of ***IM / Health Urgent Care*** and their employees participating in my care.

With my consent, ***IM / Health Urgent Care*** may use and disclose Protected Health Information (PHI**)** about me to carry out treatment, payment, and healthcare operations. Please refer to the ***IM / Health Urgent Care*** Notice of Privacy Practices for a more complete description of such uses and disclosures.

With my consent, ***IM / Health Urgent Care*** may call my home or other designated location and leave a message on voice mail in reference to any items that assist the practice in carrying out treatment, payment, or healthcare operations, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

With my consent, ***IM Health Urgent Care*** may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, or healthcare operations such as long as they are marked

With my consent, I authorize ***IM / Health Urgent Care*** to release medical information regarding the care and treatment I have received from this office to the physicians I have listed.

I have the right to request that ***IM / Health Urgent Care*** restricts how it uses or discloses my **PHI** to carry out treatment, payment or healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I authorize payment of insurance benefits directly to ***IM / Health Urgent Care.*** I understand that I am fully responsible for any medical or surgical charge incurred in the course of my treatment, co-pay, deductible, all other charges determined to be patient responsibility or other type of unpaid service in excess of any hospitalization or health insurance that might be applicable.

I hereby authorize ***IM / Health Urgent Care*** to release pertinent information to my health insurance companies required in the course of my examination or treatment.

I may revoke my consent 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***, IM / Health Urgent Care*** has the right to decline to provide treatment to me.

By signing this form, I am consenting ***IM / Health Urgent Care's*** use and disclosure of my personal health information to carry out treatment, payment and healthcare operations.

By signing this form, I acknowledge that ***IM / Health Urgent Care*** exclusively sends lab specimens to LabCorp. I understand that sending a specimen to a lab not authorized by my health insurance plan could result in an unexpected bill that will be my responsibility to pay.

**Printed Name of Patient:** _____**Date:**_____

**Patient OR Guardian Signature:**_____