Adolescent & Young Adult Medicine, P.S.

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PATIENT CONSENT FORM

Use and Disclosure of Protected Health Information

Please initial on each line as appropriate

I hereby give my consent for **Adolescent and Young Adult Medicine, P.S.** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

____I have received/reviewed a copy of The Complete Federal Notice of Privacy Practices [may be viewed/printed at www.adolescentmedicine.com] provided by **Adolescent and Young Adult Medicine, P.S.** prior to signing this consent, [which describes such uses and disclosures more completely.]

Adolescent and Young Adult Medicine, P.S. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Privacy officer, Adolescent & Young Adult Medicine, P.S., P.O.Box 12257, Olympia, WA 98508 or may be viewed/printed at www.adolescentmedicine.com**

Adolescent & Young Adult Medicine, P.S. staff, may contact me as below so that they can carry out treatment, payment and healthcare operations. [TPO] This contact defines how we may contact you about appointments, insurance concerns, lab tests, need for follow up care or any other task necessary to provide health care.

____Call my home at_____

____and leave a voice mail

____Leave message with parent, sibling or roommate

____Mail a letter to my home [appointment reminders, patient statements]

____Fax my medical information to _____

____Doctor or counselor may return calls to me via their mobile phones

____Doctor or counselor may respond to your email requests for non-urgent (not an emergency) concerns

By signing this form, I am consenting to allow **Adolescent and Young Adult Medicine, P.S.** to use and disclose 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 upon my prior consent. If I do not sign this consent, or later revoke it, **Adolescent and Young Adult Medicine, P.S.** may decline to provide treatment to me.

Patient signature_____ Date _____Age____

Parent signature_____Date _____