East Scottsdale Medical Care

Patient Consent for Use and Disclosure
Of Protected Health Information

With my consent, East Scottsdale Medical Care may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to East Scottsdale Medical Care's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing the consent. East Scottsdale Medical Care 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 East Scottsdale Medical Care, 10565 N 114th Street, Suite 103, Scottsdale, AZ 85259.

With my consent, East Scottsdale Medical Care 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 my clinical care, including laboratory results among others.

With my consent, East Scottsdale Medical Care may mail/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 as long as they are marked Personal and Confidential. I have the right to request that East Scottsdale Medical Care 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, is bound by this agreement.

By signing this form, I am consenting to East Scottsdale Medical Care'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 upon my prior consent. If I do not sign this consent, East Scottsdale Medical Care may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian