Heal Thyself LLC

4000 Mitchellville RoadSuite A308,BOWIE,MD20716 Ph: (301) 850-2069 Fax: (301) 893-7584

Patient Consent For Disclosure Of Protected Health Information

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for HEAL THYSELF, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).
(The Notice of Privacy Practices provided by HEAL THYSELF, LLC describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. HEAL THYSELF, LLCreserves 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 Karen Orellana, 4000 Mitchellville Road, Suite A308, Bowie, MD, 20716, 301-850-2069

With this consent, HEAL THYSELF, LLC may call my home or other alternative 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 calls pertaining to my clinical care, including laboratory test results, among others.

With this consent,HEAL THYSELF, LLC may mail to my home or other alternative 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.”

With this consent, HEAL THYSELF, LLC may e-mail to my home or other alternative 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 HEAL THYSELF, LLC restrict how it uses or discloses my PHI to carry out TPO. 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 allow HEAL THYSELF, LLC 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, HEAL THYSELF, LLC may decline to provide treatment to me.

Patient Name (Print: first, last)_____

Patient Signature _____ Date: _____