WellMed Your Healthcare Companion for Life® | Physicians Health Choice™ For Health. For Wellness. For Life. | ComfortCare Transportation A WellMed Company | Citrus Health Care™ "A Health Maintenance Organization"

PATIENT CONSENT FORM
For Treatment, Payment, Health Care Operations or Release of PHI

Name of Patient: _____ **Date Of Birth:** _____

Doctor/Clinic: _____

GENERAL INFORMATION

As a patient of WellMed Medical Group (WellMed), when you seek medical advice or receive medical care from us, Protected Health Information **(PHI)** will be generated about you. This information includes your medical information (past, present, and future) and personal information such as your name, address, and social security number. This information will be used for the treatment of your medical conditions(s), obtaining payment from your insurance company, and for healthcare operations within WellMed.

NOTICE OF PRIVACY PRACTICES

For a description of how your PHI may be used and disclosed, you may review WellMed's "Notice of Privacy Practices" prior to signing this consent. WellMed reserves the right to change the Notice and will notify all patients of such changes prior to the effective date.

PATIENT RIGHTS

You have the right to request a restriction of the uses and disclosures of your Protected Health Information (PHI) for the purpose of your treatment, payment for your services, and the healthcare operations of WellMed. We are not required to agree to the requested restrictions but we are bound by any restrictions agreed upon.

PERMISSION TO RELEASE YOUR PROTECTED HEALTH INFORMATION TO AUTHORIZED PERSON(S)

Please indicate below the person's name(s) to whom you authorize us to release medical and/or insurance information.

Name: _____ **Relationship:** _____ **Date of Birth:** _____

Name: _____ **Relationship:** _____ **Date of Birth:** _____

Name: _____ **Relationship:** _____ **Date of Birth:** _____

WellMed has the right to refuse to treat you if you refuse to sign this consent or, if at anytime, you choose to revise this consent. In addition, WellMed is authorized by law to use and/or disclose your PHI in certain circumstances without your consent. Your signature below acknowledges:

- You have read and understand this consent.
- You agree to have your Protected Health Information used and disclosed by WellMed for the purpose of your treatment, to secure payment for your treatment, and for WellMed's healthcare operations.
- Prior to signing this consent, you were given an opportunity to review WellMed's "Notice of Privacy Practices."
- You are permitting the release of your Protected Health Information to the person(s) listed above.
- You are aware that you may request restrictions, now or at anytime, to the use and disclosure of your Protected Health Information.

_____ _____

Signature of Patient or Patient's Legal Representative **Date**

_____

Printed Name of Legal Representative (Include legal documentation if not on file already)