OWENSBORO
Medical Practice

□ Owensboro Heart & Vascular
□ Owensboro Primary Care
□ Immediate Care Center
□ The Hancock Clinic
□ The McLean Clinic
□ The Muhlenberg Clinic
□ Owensboro Advanced Sleep Center
□ Owensboro Physical Therapy
□ Rejuve
□ Research Integrity

DATE: _____

PATIENT NAME: _____

Date of Birth: _____

Medical Record #: _____

PRIVACY CONSENT FORM FOR DISCLOSURE OF PATIENT INFORMATION FOR THE PURPOSES OF TREATMENT AND PAYMENT

- I consent to Owensboro Medical Practice, PLLC using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out Owensboro Medical Practice's health care operations.
- I consent to Owensboro Medical Practice, PLLC using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity.
- I consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.
- I consent to the disclosure of my protected health information for research purposes, if certain conditions are met.

Specific Records Expressly Included. I expressly authorize release of the following information for the purposes of treatment, payment and health care operations, if it is part of my protected health information (CHECK ANY OR ALL YOU AGREE TO AUTHORIZE FOR RELEASE):

- Chemical Dependency/Substance Abuse
  - Drugs
  - Alcohol
- Sexually Transmitted Diseases

I further acknowledge Owensboro Medical Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

(LIST FAMILY OR FRIENDS WE CAN DISCUSS REGARDING YOUR MEDICAL CARE AND/OR BILL)

NOTE: This release is applicable for any of the Owensboro Medical Practice entities listed at the top of this form.

RELEASE INFO TO: _____ (Relationship)

_____

_____

□□ Please check if office is able to leave message on answering machine or voice mail.

DATE: _____ **SIGNATURE:** _____