



HIPAA Patient Consent Form

IMPACT ORTHOPAEDICS

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Impact Orthopaedics (IO)** consent to provide medical treatment in treating my physical condition and 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 **IO** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

IO 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 **Impact Orthopaedics, 3320 Wake Forest Road, Suite 100, Raleigh, NC 27609.**

With this consent, **IO** 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, **IO** 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, **IO** 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 **IO** 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 **IO** 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, **IO** may decline to provide treatment to me.

I authorize release of my medical information to the following companies or individuals:

_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone

I have read and understand this information. I have received a copy of the Notice of Privacy and I am the patient or am authorized to act on behalf of the patient to sign this document verifying consent to the above stated terms.

Signature of Patient or Legal Guardian

Print Patient's Name / DOB

Date

Print Name of Patient or Legal Guardian, if applicable