Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Ohio Institute of Osteopathic Medicine, 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 Ohio Institute of Osteopathic Medicine, LLC describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Ohio Institute of Osteopathic Medicine, LLC 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:

Ohio Institute of Osteopathic Medicine, LLC
93 North Washington Street
Tiffin, Ohio 44883

With this consent, Ohio Institute of Osteopathic Medicine, 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, Ohio Institute of Osteopathic Medicine, 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, Ohio Institute of Osteopathic Medicine, 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 Ohio Institute of Osteopathic Medicine, 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.

With this consent, Ohio Institute of Osteopathic Medicine, LLC may disclose and discuss my medical condition with the following family member(s) or individuals:

_____

_____

_____

By signing this form, I am consenting to allow Ohio Institute of Osteopathic Medicine, 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, Ohio Institute of Osteopathic Medicine, LLC may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable