Rooks County Health Center
1210 N Washington | P.O. Box 389
Plainville, KS 67663
DocsWithoutDelay.com
785.688.DOCS(3627)

PATIENT CONSENT FORM

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT CONSENT FORM

- I hereby give my consent for Doctors Without Delay to use and disclose my protected health information to carry out treatment, payment and health care operations. Doctors Without Delay's Notice of Privacy Practices provides a more complete description of such uses and disclosures. By signing this form, I am consenting to Doctors Without Delay's use and disclosure of my protected health information to carry out treatment, payment and health care operations.
- By signing this form, I agree to have reviewed the Notice of Privacy Practices. Doctors Without Delay reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by sending a written request to the office at 1210 N. Washington, Plainville, KS 67663.
- With this consent, Doctors Without Delay may call my home or alternate phone numbers provided by me and leave a message or speak in person regarding any items that assist the practice in carrying out treatment, payment and health care operations, such as appointment reminders, insurance information and calls regarding clinical care.
- With this consent, Doctors Without Delay may mail to my home or alternate locations provided by me any items that assist the practice in carrying out treatment, payment and health care operations, such as appointment reminder cards and patient statements, so long as they are marked confidential.
- I have the right to request that Doctors Without Delay restrict how it uses or discloses my protected health information to carry out treatment, payment and health care operations. Doctors Without Delay will comply with my requests in good faith and to the best of its abilities.
- By signing this form, I hereby authorize payment directly to the medical provider of benefits due me for the services rendered by a health care provider of Doctors Without Delay. I understand that I am responsible for charges not covered by this authorization.
- I also understand that there may be times when my health care provider orders tests that my insurance deems unnecessary. I agree to be responsible for these charges.
- I also understand that laboratory and radiology (x-ray) charges are separate from the Doctors Without Delay's visit charge. Any questions I have about laboratory or radiology billing should be addressed directly to the billing facility.
- I may revoke my consent in writing except to the extent that Doctors Without Delay has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Doctors Without Delay may decline to provide treatment to me.
- I certify that I have read and fully understand this document and have been given the option of receiving a copy of it. I, as the patient or legal guardian of the patient, indicate agreement with all the terms and statements above in signing this document.

Patient's Name Printed: ______________________________ **Date:** _____ /_____ /__________

Signature of Patient/Legal Guardian: ______________________________

Signer's Relationship to Patient: ______________________________