

Speer Primary Care
445A Carlisle Drive
Herndon VA 20170

CONSENT FORM
**(FOR Use and Disclosure of Protected Health Information for Treatment,
Payment, or Healthcare Operations (TPO))**

I understand that as part of my healthcare, Speer Primary Care originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that I may request a copy of the **Notice of Information Practices** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand the Provider reserves the right to change their notice and practices, and a need to use or disclose any protected health information. I also understand that I have the right to restrict as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Provider is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Provider had already taken action in reliance thereon. Any patient, guardian or personal representative has the right to request to receive confidential communications of protected health information by alternative means or at alternative locations. Such requests must be in writing and the provider must accommodate reasonable request.

With the consent, Speer Primary Care may mail to my home or other designated location any times that assist the practice in carrying out TPO, such as appointment reminders and other correspondence as long as they are marked Personal and Confidential.

With this consent, Speer Primary Care may call/text/email me appointment reminders and email/mail my patient statements. I have the right to request that Speer Primary Care restricts how it uses or discloses my PHI to carry out TPO. However, the Provider 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 giving my consent to Speer Primary Care 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.

Printed Name of Patient

Patient/Legal guardian signature

Date