Consent

Patient's Name ___________________________________Date of Birth ______________

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **(Advance Therapy Works Inc.)** PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

❑ I give permission to **Advance Therapy Works Inc.)** to contact me using my address, phone number, e-mail, or via text message and to access my clinical records or other Protected Health Information to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, provider's newsletters, information about treatment alternatives, other health related information including but not limited to marketing communications.

❑ If **Advance Therapy Works Inc.** contacts me by e-mail, text message or by phone, I give permission to leave a phone message on my answering machine or voice mail.

(OPEN TREATMENT ROOM AUTHORIZATION-OPTIONAL)
I give **Advance Therapy Works In** permission to treat me in an open room where other patients may also be being treated. I am aware that other persons in that room or the provider's office may overhear some of my protected health information during the course of care. Should I need to speak with my provider or doctor at any time in private, **Advance Therapy Works Inc** will provide a room for these conversations.

I do hereby give my consent to and authorize **Advance Therapy Works Inc.** to release to my insurance company such information from my medical records as may be necessary for the completion and processing of my claim. Advance Therapy Works Inc. is authorized to furnish this information even though the confidentiality of the information may be protected by Federal and State Laws and Regulations. Advance Therapy Works Inc. is hereby released and discharged of any liability.

❑ By signing this form you are giving provider permission to use and disclose your protected health information in accordance with the directives listed above.

Notice of Privacy Acknowledgement

■ **I acknowledge that the Notice of Privacy Practice is available upon request.**

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of provider. The written notice must contain the following information: Your name, Social Security number and date of birth; A clear statement of your intent to revoke this AUTHORIZATION; The date of your request; and Your signature. The revocation is not effective until it is received by the provider's Privacy Official.

This AUTHORIZATION is requested by provider for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, provider will not refuse to provide treatment. You have the right to inspect or copy the PHI to be used/disclosed.

______________________________________ ______________________
Patient's Signature Date

HEALTH CARE AUTHIRATION FORM