**Valley Diagnostic Medical Center**
**Patient Consent for Use and Disclosure**
**of Protected Health Information**

I hereby give my consent for Valley Diagnostic Medical Center 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 Valley Diagnostic Medical Center describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Valley Diagnostic Medical Center 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 Valley Diagnostic Medical Center.

With this consent, Valley Diagnostic Medical Center 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, Valley Diagnostic Medical Center 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.

With this consent, Valley Diagnostic Medical Center 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 Valley Diagnostic Medical Center 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 Valley Diagnostic Medical Center to use and disclose my PHI to carry out TPO.

Please list any family members/persons whom you will permit your medical/billing information to be shared with:

Name: _____ Relationship to patient: _____
Telephone: _____

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, Valley Diagnostic Medical Center may decline to provide treatment to me.

_____ _____
Signature of Patient or Legal Guardian Print Name of Legal Guardian, if applicable

_____ _____
Print Patient's Name Date