MYOFASCIAL RELEASE OF SOUTHERN ILLINOIS

HIPAA CONSENT FORM

I give Myofascial Release of Southern Illinois my consent to disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this clinic has the right to change their privacy practices and that I may obtain any revised notices at the clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the clinic is not required to agree to the request. If the clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for the information already used or disclosed.

With this consent, Myofascial Release of Southern Illinois may call my home or other alternative phone numbers and leave a message on voice mail or to any person answering the phone in reference to any items that assist the office in carrying out treatment, payment and health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care.
____ (INITIAL)

Signature: _____Date: _____

Patient, parent, or legal guardian

If signed by patient representative, state relationship to patient: _____

101 South Graham Ave, Suite 3, Carbondale, IL 62901
Office: (618)-305-4696 Fax: (888)-975-0097
admin@mfrofsi.com