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Consent for Use and Disclosure of Protected Health Information for Treatment, Payment or Health Care Operations

TO: PRIVACY OFFICER

FROM: _____
(Name of Individual)

(Name of Provider)

(Address)

I hereby acknowledge and consent to the use of my protected health information:

- to carry out treatment, payment and health care operations (TPO), such as receiving and paying bills, directly or by reimbursement;
- to call my home and leave a message in reference to TPO (such as a message concerning my coverage) on an answering machine or with a family member or friend answering the telephone and identifying themselves as such;
- to mail or email to my home items relating to TPO, such as matters pertaining to my coverage or reimbursements.

By signing this form, I am consenting to Dr. Connell's use and disclosure of my protected health information to carry out TPO.

Signature (Individual or Personal Representative)

Date: _____

Name of Personal Representative (if applicable)