TROY ORTHOPEDIC ASSOCIATES

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Troy Orthopedic Associates, may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and healthcare Operations (TPO). Please refer to Troy Orthopedic Associates Notice of Privacy Practices for more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.
Troy Orthopedic Associates reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Troy Orthopedic Associates Privacy Officer at 1350 Kirts, Suite #160, Troy, MI 48084.

With my consent, Troy Orthopedic Associates may call my home or other designated 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 call pertaining to my clinical care, including laboratory results among others.

With my consent, Troy Orthopedic Associates, may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as patient statements and collections letters.

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

By signing this form, I am consenting to Troy Orthopedic Associates use and disclosure of 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. If I do not sign this consent, Troy Orthopedic Associates my decline to provide treatment to me.

Information may be released to the following people:

_____	_____	_____
Signature of Patient/Legal Guardian	Name	Relationship
_____	_____	_____
Date	Name	Relationship
_____	_____	_____
Print Patient's Name	Name	Relationship
_____	_____	_____
Print Name of Legal Guardian	Name	Relationship