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Patient CONSENT for Physician to use or disclose health care information for treatment, payment and health care operations.

Patient's name: _____ DOB: _____

SSN: _____ ACCT#: _____

I understand that signing this document means that Marvel Clinic or Center for Day Surgery may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health care operations. Failure to sign this consent may result in the physician declining to treat me.

Marvel Clinic and Center for Day Surgery has a detailed document called the "HIPPA Notice of Privacy Practices". It contains more information about the policies and practices used to protect their patient's privacy. I have read and signed the "Notice".

Under the terms of this consent, I can restrict how my personal health information is used or disclosed to carry out treatment, payment, or health care operations.

I consent to the following:

<input type="checkbox"/> YES	<input type="checkbox"/> NO	May the staff telephone your home? If no, another contact phone is required: _____
<input type="checkbox"/> YES	<input type="checkbox"/> NO	May the staff leave a message on an answering machine?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	May the staff leave a message with whomever answers the phone at your home or alternate contact telephone number?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	May the staff mail notices for follow up visits, test results, or educational material to your home mailing address? If no, please provide another address? _____
<input type="checkbox"/> YES	<input type="checkbox"/> NO	May the staff contact you at work?

I understand I have the right to cancel or modify this consent in writing, at any time. If I do cancel or modify the consent, I understand that information about me may have already been used or disclosed and canceling or modifying this consent would not affect the information already used or disclosed.

I further understand if I cancel this consent, it may result in the physician declining to treat me.

Patient or legally authorized individual signature

Date

Witness