

HI CARE MEDICAL CENTER’S GROUP PRIVACY CONSENT FORM

Our practice recognizes and respects the fact that all patients of Hi Care Medical Center have the right to inspect and obtain a copy of his/her records (Protected Health Information).

With my consent, Hi Care Medical Center may use and disclose any Protected Health Information about myself or my child to carry out treatment, payment, to collect any outstanding charges, and healthcare operations. Please refer to Hi Care Medical Center’s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the notice of Privacy Practices before signing this consent. Hi Care Medical Center reserves the right to revise its notice of Privacy Practices at anytime.

With my consent, Hi Care Medical Center may call my home or other designated location and leave me a message on voicemail or in person in reference to any item that assist the practice in carrying out treatment, payment, and other healthcare operations, such as appointment reminders, insurance items, payment items, and any call pertaining to my clinical care, including laboratory results and information among others.

With my Consent Hi Care Medical Center may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, and other healthcare operations, such as appointment reminder cards, patient statements, and any other information regarding my or my child’s healthcare.

I have the right to request that Hi Care Medical Center restricts how it uses and discloses my Protected Health Information to carry out treatment and payment. However 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 Hi Care Medical Center’s use and disclosure of my Protected Health Information to carry out treatment, payment and other healthcare operations.

I may revoke my Consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, Hi Care Medical Center may decline to provide treatment to me or my child.

\_\_\_\_\_  
Signature of Patient (Parent or Legal Guardian if under 18)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient’s Name (Printed)

\_\_\_\_\_  
Date of Birth