Regent Medical
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NOTICE OF PRIVACY PRACTICES AND CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Regent Medical** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **16872 N. Cave Creek Road, Phoenix AZ 85032.**

I understand that I may request in writing that **Regent Medical** restrict how my private information is used or disclosed to carry out treatment, payment and health care operations (TPO). I also understand that the practice is not required to agree to my requested restrictions, but if it does, it is bound by such restrictions.

With this consent, **Regent Medical** may call my home or other alternative location. They may leave a message on voice mail in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

I understand that I may revoke this consent in writing at any time, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Regent Medical** may decline to provide treatment to me.

AUTHORIZATION TO RELEASE INFORMATION

I, _____ DOB _____ hereby authorize **REGENT MEDICAL** to discuss my personal medical records, including X-rays and labs, with:

_____ _____
(Spouse, Siblings, etc. – EXCLUDING DOCTORS) (Relationship)

_____ _____
(Spouse, Siblings, etc. – EXCLUDING DOCTORS) (Relationship)

REGENT MEDICAL MAY LEAVE A MESSAGE ON MY:

☐ HOME NUMBER ☐ CELL NUMBER ☐OTHER: _____

I understand that I may revoke this at any time in writing.

PATIENT PRINTED NAME: _____
RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____
DATE: _____