Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for ADVANCED PRACTICE NURSING SPECIALISTS to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by ADVANCED PRACTICE NURSING SPECIALISTS describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. ADVANCED PRACTICE NURSING SPECIALISTS 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 the Office Manager at ADVANCED PRACTICE NURSING SPECIALISTS 9205 W Russell Rd Suite 305, Las Vegas, NV 89148, or through viewing on the website apnshealth.com.

_____With this consent, ADVANCED PRACTICE NURSING SPECIALISTS may call my home or other alternative location, and leave a message on voicemail or in person 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.

_____With this consent, ADVANCED PRACTICE NURSING SPECIALISTS may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

_____With this consent, ADVANCED PRACTICE NURSING SPECIALISTS may e-mail to my email address any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that ADVANCED PRACTICE NURSING SPECIALISTS restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

_____With this consent, ADVANCED PRACTICE NURSING SPECIALISTS may text to my cell phone any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that ADVANCED PRACTICE NURSING SPECIALISTS restrict how it uses or discloses my PHI to carry out TPO. 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 allow ADVANCED PRACTICE NURSING SPECIALISTS to use and disclose 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, or later revoke it, ADVANCED PRACTICE NURSING SPECIALISTS may decline to provide treatment to me.

_____
Signature of Patient

_____ _____
Print Name Date

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