Voytik Center for Orthopedic Care

Release of Information/Consent for Purposes of Treatment, Payment and Healthcare Operations Health Insurance Portability and Accountability (HIPAA)

Patients Name:		Date:			
consent to the use or disobleurs of my 'protected health information: as defined in the Health Insurance Portability and Accountability Act of 1906 (HIPAA) and this Connect by Voyik Center for Orthopodic Care, PG for the process of diagnosing or providing treatment or my cellular graphs can officially come on consideration of the diagnosis of the document of my periodic care, PG in the process and that diagnosis or treatment of me by the provider(s) may be continued upon my content are desidenced by my gliptical come that content of the process of the provider of the provider of the process of the provider of the provider of the process of the process of the provider of the process of th	Patients Name:	Date	Date of Birth:		
consent to the use or disobleurs of my 'protected health information: as defined in the Health Insurance Portability and Accountability Act of 1906 (HIPAA) and this Connect by Voyik Center for Orthopodic Care, PG for the process of diagnosing or providing treatment or my cellular graphs can officially come on consideration of the diagnosis of the document of my periodic care, PG in the process and that diagnosis or treatment of me by the provider(s) may be continued upon my content are desidenced by my gliptical come that content of the process of the provider of the provider of the process of the provider of the provider of the process of the process of the provider of the process of th	Address:	City	State		
Physical or metal health care provider. a health plan, my employer of a health care cleaninghouse. This protected health information relates to my past, present or future physical or metal feath of condition and dentifies me, or three is a reasonable basis to believe such information may be controlly metal. The physical or metal feath of condition and dentifies me, or three is a reasonable case; P. B. Or three or three or three or three is a reasonable case; P. B. Or three o	I consent to the u Accountability Act of 1996 (HIPAA) and this Consent by Voytik for my health care bills or to conduct the health care operation	use or disclosure of my "protected health inform Center for Orthopedic Care, PC for the purpose of s of Voytik Center for Orthopedic Care, PC. I undo	ation: as defined in the Health Ir diagnosing or providing treatment to	nsurance Portability and o me, obtaining payment	
operations of Voytik Center for Orthopedic Care, P.C. voytik Center for Orthopedic Care, P.C. after sets or any restriction required to agree to any restriction hat I may required. It in the understand that I have the right to revoke this consent, in writing, at any time, except to the extent that the providency or Voytik Center for Orthopedic Care, P.C. and the providency of the provid	Physician, another health care provider, a health plan, my em	ployer or a health care clearinghouse. This protect	cted health information relates to m		
## spiontiment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you. I understand I have a reminders are a service provided by my physician as a counteys. I could be contact by a presence demessage and by providing a cell phone number I consent to neceive such calls. **Understand I have a right to review Voylik Center for Orthoppedic Care's Notice of Privacy Practices prior to signing this Consent. Voylik Center for Orthoppedic Care's Notice of Privacy Practices prior to signing this Consent. Voylik Center for Orthoppedic Care's Notice of Privacy Practices prior to signing this Consent. Voylik Center for Orthoppedic Care's Allies on the performance of the health care operations of Voylik Center for Orthoppedic Care's Allies with respect to my protected health information and the privacy Practices also describes my rights and Voylik Center for Orthoppedic Care's duties with respect to my protected health information. **Please also note that a provided in Ovolik Center for Orthoppedic Care's Orthoppedic	operations of Voytik Center for Orthopedic Care, PC. Voytik C Center for Orthopedic Care, PC agrees to any restriction reque further understand that I have the right to revoke this consent,	enter for Orthopedic Care, PC is not required to ag ested by me, such restriction shall be binding on V	ree to any restriction that I may req oytik Center for Orthopedic Care, P	uest. If, however, Voytik PC and the provider(s). I	
Notice of Privacy Practices has been provided to me and describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment of my bills or in the performance of the health care operations of Voyik Center for Orthopedic Care, P.C. This Notice of Privacy Practices also describes my rights and Voyik Center for Vorthopedic Cares out the with respect to my protected health information. Please also note in Voyik Center for Orthopedic Care, P.C. This Notice of Privacy Practices, Voyik Center for Orthopedic Care, P.C. This Notice of Privacy practices by calling the office at (423) 479-3600 and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment. - As required by privacy regulations, this practice may not use or disclose your protected health information except as provided in our notice of privacy practices without your authorization. - I hereby authorize the Voyik Center for Orthopedic Care to use or disclose my patient health information to the following person(s). Name:	appointment for medical care, or to contact you to tell you abovou. I understand that appointment reminders are a service programment of the contact you are a service programment.	out possible treatment options or alternatives or he	alth related benefits and services the	hat may be of interest to	
privacy practices that are described in such notice. I may obtain a revised notice of privacy practices by calling the office at (423) 479-3600 and requesting a revised copy be sent in the mail or an exit he time of my next appointment. -As required by privacy regulations, this practice may not use or disclose your protected health information except as provided in our notice of privacy practices without your authorization. -I hereby authorize the Voytik Center for Orthopedic Care to use or disclose my patient health information to the following person(s). 1) Name:	Notice of Privacy Practices has been provided to me and des payment of my bills or in the performance of the health care of	cribes the types of uses and disclosures of my pr perations of Voytik Center for Orthopedic Care, PC	otected health information that may	y occur in my treatment,	
In hereby authorize the Voylik Center for Orthopedic Care to use or disclose my patient health information to the following person(s). In Name:	privacy practices that are described in such notice. I may obtain	in a revised notice of privacy practices by calling the			
Name:		r disclose your protected health information except	as provided in our notice of privacy	practices without your	
Phone:	-I hereby authorize the Voytik Center for Orthopedic Care to use	e or disclose my patient health information to the fol	llowing person(s).		
Phone:	1) Name:		DOB:		
Phone:	Relationship to Patient:	Phone:		_	
Trequest that my electronic protected health information be transmitted via email to the following individual at the email address listed below. I understand that if this email is not encrypted, that the transmission of this information is not considered secure and may be accessible by unauthorized individuals. I acknowledge that I am aware of these risks and I give my permission to email my protected health information to the following individual: -By providing an email address, I consent to receive E-statements to the below email. If I choose not to provide an email address, I am subject to a paper statement fee of \$2.50. Name of Individual (Patient or Guardian) to Receive Electronic Protected Health Information Email Address NOTICE: Voytik Center for Orthopedic Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Voytik Center for Orthopedic Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Voytik Center for Orthopedic Care or complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Voytik Center for Orthopedic Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Voytik Center for Orthopedic Care provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters. We provide free language services to people whose primary language is not English, language assistance services, free of charge, are available to you. Si usted habla español, tiene a su disposición servicios de asistencia con el idioma sin costo alguno. Di subject de la la ma aware of these risks and I give my permission to provide an email address. I am subject to a paper statement fee of \$2.50.	2) Name:		DOB:	_	
that the transmission of this information is not considered secure and may be accessible by unauthorized individuals. I acknowledge that I am aware of these risks and I give my permission to email my protected health information to the following individual: By providing an email address, I consent to receive B-statements to the below email. If I choose not to provide an email address, I am subject to a paper statement fee of \$2.50. Name of Individual (Patient or Guardian) to Receive Electronic Protected Health Information Email Address NOTICE: Voytik Center for Orthopedic Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Voytik Center for Orthopedic Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Voytik Center for Orthopedic Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Voytik Center for Orthopedic Care provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters. We provide free language services to people whose primary language is not English, including a qualified interpreter. If you speak English, language assistance services, free of charge, are available to you. Si usted habla español, tiene a su disposición servicios de asistencia con el idioma sin costo alguno. ### Particular ** **Description** **De	Relationship to Patient:	Phone:			
Email Address NOTICE: Voytik Center for Orthopedic Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Voytik Center for Orthopedic Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Voytik Center for Orthopedic Care provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters. We provide free language services to people whose primary language is not English, including a qualified interpreter. If you speak English, language assistance services, free of charge, are available to you. Si usted habla español, tiene a su disposición servicios de asistencia con el idioma sin costo alguno. Ul Si usted habla español, tiene a su disposición servicios de asistencia con el idioma sin costo alguno. Ul Si usted habla español, tiene a su disposición servicios de asistencia con el idioma sin costo alguno. Ul Si usted habla español, tiene a su disposición servicios de asistencia con el idioma sin costo alguno. Ul Si usted habla español, tiene a su disposición servicios de asistencia con el idioma sin costo alguno. Ul Si usted habla español, tiene a su disposición servicios de asistencia con el idioma sin costo alguno. Ul Si usted habla español, tiene a su disposición servicios de asistencia con el idioma sin costo alguno. Ul Si usted habla español, tiene a su disposición servicios de asistencia con el idioma sin costo alguno. Ul Si usted habla español, tiene a su disposición servicios de asistencia con el idioma sin costo alguno. Ul Si usted habla español, tiene a su disposición servicios de asistencia con el idioma sin costo alguno. Ul Si usted habla español, tiene a su disposición servicios de asistencia con el idioma sin costo alguno. Ul Si usted habla español, tiene a su disposición servicios de asistencia con el idioma sin costo alguno. Ul Si usted habla españ	that the transmission of this information is not considered secure and email my protected health information to the following individual:	may be accessible by unauthorized individuals. I acknow	ledge that I am aware of these risks and	I give my permission to	
NOTICE: Voytik Center for Orthopedic Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Voytik Center for Orthopedic Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Voytik Center for Orthopedic Care provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters. We provide free language services to people whose primary language is not English, including a qualified interpreter. If you speak English, language assistance services, free of charge, are available to you. Si usted habla español, tiene a su disposición servicios de asistencia con el idioma sin costo alguno. [Name of Individual (Patient or Guardian) to Reco	eive Electronic Protected Health Inform	ation		
Voytik Center for Orthopedic Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Voytik Center for Orthopedic Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Voytik Center for Orthopedic Care provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters. We provide free language services to people whose primary language is not English, including a qualified interpreter. If you speak English, language assistance services, free of charge, are available to you. Si usted habla español, tiene a su disposición servicios de asistencia con el idioma sin costo alguno. In provide free language services to people whose primary language is not English, including a qualified interpreter. If you speak English, language assistance services, free of charge, are available to you. Si usted habla español, tiene a su disposición servicios de asistencia con el idioma sin costo alguno. In provide free language services to people whose primary language is not English, including a qualified interpreter. If you speak English, language assistance services, free of charge, are available to you. Si usted habla español, tiene a su disposición servicios de asistencia con el idioma sin costo alguno. In provide free language services to people whose primary language is not english, including a qualified interpreter. If you speak English, language assistance services, free of charge, are available to you. Si usted habla español, tiene a su disposición servicios de asistencia con el idioma sin costo alguno. In provide free language services to people whose primary language is not english, language interpreters. If you speak English, language assistance services, free of charge, are available to you. Si usted habla español, tiene a su disposición servicios de asistencia con el idiom	Email Address				
Si usted habla español, tiene a su disposición servicios de asistencia con el idioma sin costo alguno. إذا كت تتحدث العربية، فستر في لك خدمات المساعد النوية مجاثا 如果您讲汉语普通话,则可以免费向您提供语言协助服务。 I acknowledge that I have read and understand the above information in its entirety. I understand that this information can be re-disclosed at any time. Signature of Authorizing Patient: Effective Date:/	Voytik Center for Orthopedic Care complies with applicable Federal of Orthopedic Care does not exclude people or treat them differently services to people with disabilities to communicate effectively with us	because of race, color, national origin, age, disability, or	sex. Voytik Center for Orthopedic Car	e provides free aids and	
I acknowledge that I have read and understand the above information in its entirety. I understand that this information can be re-disclosed at any time. Signature of Authorizing Patient:	Si usted habla español, tiene a su disposición servicios de asistencia co إذا كنت تتحدث العربية، فسنتوفر لك خدمات المساعدة اللغوية مجانًا.				
Signature of Authorizing Patient: Effective Date://	如朱心 讲汉语普通话,则可以免费问您提供语言协助服务。				
	I acknowledge that I have read and understand the above info	ormation in its entirety. I understand that this infor	rmation can be re-disclosed at any	time.	
Authorized Witness: Date:revised 12.1.16	Signature of Authorizing Patient:	E1	ffective Date:/	/	
	Authorized Witness:		Date:	revised 12.1.16	