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

Date: ________________________

Patients Name:____ Date of Birth: _________________

Address: ___________________________________City______________________State____________

I _______________________________ consent to the use or disclosure of my "protected health information: as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and this Consent by Voytik Center for Orthopedic Care, PC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the health care operations of Voytik Center for Orthopedic Care, PC. I understand that diagnosis or treatment of me by the provider(s) may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" means health information, including but not limited to my demographic information, collected from me and created or received by my Physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe such information may identify me.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or the healthcare operations of Voytik Center for Orthopedic Care, PC. Voytik Center for Orthopedic Care, PC is not required to agree to any restriction that I may request. If, however, Voytik Center for Orthopedic Care, PC agrees to any restriction requested by me, such restriction shall be binding on Voytik Center for Orthopedic Care, PC and the provider(s). I further understand that I have the right to revoke this consent, in writing, at any time, except to the extent that the provider(s) or Voytik Center for Orthopedic Care, PC has taken action in reliance on this Consent.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services. We may use and disclose PHI to contact you to remind you that you have an appointment 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 that appointment reminders are a service provided by my physician as a courtesy. I could be contact by a prerecorded message and by providing a cell phone number I consent to receive such calls.

I understand I have a right to review Voytik Center for Orthopedic Care's **Notice of Privacy Practices** prior to signing this Consent. Voytik Center for Orthopedic Care's 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 Voytik Center for Orthopedic Care, PC. This Notice of Privacy Practices also describes my rights and Voytik Center for Orthopedic Care's duties with respect to my protected health information.

Please also note that as provided in Voytik Center for Orthopedic Care's Notice of Privacy Practices, Voytik Center for Orthopedic Care, PC reserves the right to change the 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 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 Voytik Center for Orthopedic Care to use or disclose my patient health information to the following person(s).

1) Name:____ DOB: _____________
   Relationship to Patient: ___________________________ Phone: ________________________________

2) Name:____ DOB: _____________
   Relationship to Patient: ___________________________ Phone: ________________________________

-I request 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 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.
إذا كنت تتحدث العربية، فستتوفر لك خدمات المساعدة اللغوية مجانًا.
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:** ____/____/_______

Authorized Witness: ____ Date: _________________ revised 12.1.16