BEST SURGERY & THERAPIES

AUTHORIZATION OF PRIVACY INFORMATION

AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by BEST Surgery & Therapies in order to carry out treatment, payment, or health care operations.

I acknowledge that I have been provided with a copy of BEST Surgery & Therapies Privacy & Security Practices Notice to review a complete description of privacy practices and the potential release and use of your protected health information, and that it is right to review such Notice prior to signing this Consent Form.

I acknowledge that BEST Surgery & Therapies reserves the right to change the terms of its privacy practices at any time and that in the event the terms of BEST Surgery & Therapies Privacy & Security Practices Notice change, you I will be notified as required by prevailing laws and may also request a current copy of our the Notice by requesting a copy from our the BEST clinic's front desk staff at any time.

I understand that I retain the right to request to change my consent to the below disclosures, and that I must do so in writing. I understand I may request that BEST Surgery & Therapies further restrict how your my protected health information is released or used to carry out care, payment, or heath care operations.

Please Note: BEST Surgery & Therapies encourages you to read the privacy practices and standards of your email and phone provider(s) as their privacy policy may differ from those of BEST Surgery & Therapies.

IN CONSIDERATION OF ABOVE, I AGREE AND CONSENT TO RELEASING INFORMATION TO ME IN THE FOLLOWING MANNERS:

	CONTACT INFO	DATE
VIA EMAIL		
☐ Ok to send PHI to email address	_____	_____
☐ Ok to send PHI to alternate email	_____	_____
VIA HOME TELEPHONE		
☐ Ok to leave detailed message	_____	_____
☐ Leave call back number only	_____	_____
VIA CELL PHONE		
☐ Ok to leave detailed message	_____	_____
☐ Leave call back number only	_____	_____
VIA ALTERNATE COMMUNICATION METHOD		
☐ Ok to leave detailed message	_____	_____
☐ Leave call back number only	_____	_____
☐ Ok to FAX PHI to:_____	_____	_____

BY SIGNING BELOW, I ATTEST THAT THE INFORMATION PROVIDED ABOVE IS TRUE AND ACCURATE.

SIGNATURE _____ DATE _____