David P. Stapenhorst, M.D., F.A.C.S.
Plastic and Reconstructive Surgery

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for David P. Stapenhorst, M.D., F.A.C.S., to use and disclose protected health information (PHI) about me to carry out treatment, payments, and healthcare operations (TPO). The notice of Privacy Practices provided by Dr. David P. Stapenhorst describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing the consent. Dr. David P. Stapenhorst reserved the right to revise the Notice of Privacy Practices at any time. A revised notice may be obtained by forwarding a written request to our office.

With this consent, Dr. David P. Stapenhorst may call my home or other alternative locations and leave a message on voicemail or in person in reference to any items that assist they practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, treatment, payment, and healthcare operations including laboratory test results, among others.

With this consent, Dr. David P. Stapenhorst may mail to my home or other alternative locations any items that assist the practice in carrying out treatment, payment, or other, such as appointment reminder notices and patient statements.

With this consent, Dr. David P. Stapenhorst may e-mail to my home or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminder notices and patient statements. I have the right to request that Dr. David P. Stapenhorst restrict how to use or disclose 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 Dr. David P. Stapenhorst 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, David P. Stapenhorst, M.D., F.A.C.S. may decline to provide treatment to me.

____
Patient Name (Please print)

____ ____________________________
Signature of Patient or Legal Guardian Date

____
Name of Legal Guardian, if applicable (Please print)

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