Personal Health Information Release

I hereby give my consent for the LiveOn Health Center to use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (The LiveOn Health Center's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. The LiveOn Health Center reserves the right to revise its Notice of Privacy Practices at any time. A copy of the Notice of Privacy Practices may be obtained by sending a written request to:

LiveOn Health Center
290 Country Club Drive, Suite 220
Stockbridge, GA 30281
Attn: Director of Practice Management

☐ With this consent, the LiveOn Health Center may call my home phone or other alternative number provided by me 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 results among others.

_____
PHONE NUMBER(s)

☐ With this consent I give the LiveOn Health Center my permission to release any personal health information to the following person(s):

_____ _____
NAME / RELATIONSHIP DATE

_____ _____
NAME / RELATIONSHIP DATE

☐ With this consent, the LiveOn Health Center may mail to my home or alternative location provided by me any items that may assist the practice in carrying out TPO, such as appointment reminders, patient statements and lab results.

_____
HOME ADDRESS – STREET ADDRESS / CITY / STATE / ZIP

_____
ALTERNATIVE ADDRESS – STREET ADDRESS / CITY / STATE / ZIP

PLEASE COMPLETE NEXT PAGE

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☐ With this consent the LiveOn Health Center may email to the address(es) I provide below any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements, lab results and other personal health information, understanding that email is not a secure transmission method and that such email may be intercepted, hacked or read by others. I understand that I am responsible for access to my email and computer and will not hold the provider's office responsible for any breach that may occur. **Any changes to my email address must be delivered in writing, and not, by email to the provider.**

_____

EMAIL L ADDRESS – PLEASE PRINT

_____

ALTERNATE EMAIL L ADDRESS – PLEASE PRINT

By signing this form I am consenting to the LiveOn Health Center's use and disclosure of my PHI to carry out TPO including the above checked means. I have the right to request that the LiveOn Health Center restrict how it uses or discloses my PHI to carry out TPO such as appointment reminders, insurance items and any information pertaining to my clinical care including laboratory results among others. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

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, the LiveOn Health Center may decline to provide treatment to me.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____

PRINTED NAME OF PATIENT OR LEGAL GUARDIAN

_____ _____

LIVEON WITNESS / APPROVAL SIGNATURE DATE

REVOCATION OF CONSENT:

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____ _____

PRINTED NAME OF PATIENT OR LEGAL GUARDIAN DATE

_____ _____

LIVEON WITNESS / APPROVAL SIGNATURE DATE