ANMED HEALTH

PATIENT CONSENT FORM

Please Note: If you have received this form by mail, please bring it with you to your next appointment. Thank you.

Our *Notice of Privacy Practices* provides information about how we may use and disclose protected health information about you and your rights with respect to your health information. You have the right to review our notice before signing this consent. As stated in our notice, the terms may change. If we change our notice, you may obtain a revised copy by requesting one from the front desk personnel. The revised notice will also be posted in our waiting room.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you also acknowledge that you have received or reviewed a copy of the *Notice of Privacy Practices.*

_____	_____
Patient Signature or Legal Guardian Signature if patient is a minor	Printed Name of Patient
_____	_____ _____
Printed Name of Legal Guardian	Date Time

FAX & EMAIL PRIVACY WAIVER

I understand that my medical records may be transmitted electronically by fax and may be received in error by a third party. In the event that this should occur I absolve this practice of all liability.

I give my consent to fax my records for the purposes of treatment, payment or healthcare operations and understand that I may withdraw this consent at any time in writing.

If I choose to email my healthcare provider(s), I understand that email is considered a convenience and is not appropriate for emergencies or time-sensitive issues. I also understand that highly sensitive or personal information should not be communicated via email.

I understand that although safeguards will be made to protect the confidentiality of any information contained within email, no one can guarantee the absolute privacy of email messages and that depending on their job function, staff may have the right to access any email sent or received by my healthcare provider(s).

I give my consent to include any emails pertinent to the treatment, payment or healthcare operations in my medical record. Finally, I understand that I may withdraw this consent at any time in writing.

_____	_____
Patient Signature or Legal Guardian Signature if patient is a minor	Printed Name of Patient
_____	_____ _____
Printed Name of Legal Guardian	Date Time