Dr. Linda Comin Psychologist Inc.
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Consent to Use PHI for Treatment, Payment, and Healthcare Operations

With my consent, Dr. Linda Comin Psychologist Inc. may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Dr. Linda Comin Psychologist Inc. Notice of Privacy Practices for 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. Dr. Linda Comin Psychologist Inc. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Linda Comin Psychologist Inc.

With my consent, Dr. Linda Comin Psychologist Inc. may call or text my cell phone or designated location and text a message or leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care. With my consent, Dr. Linda Comin Psychologist Inc. may mail to my home or other designated location any items that assist in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked Personal and Confidential.

With my consent, Dr. Linda Comin Psychologist Inc. may e-mail to me my appointment reminder cards and patient statements. I have the right to request that Dr. Linda Comin Psychologist Inc. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is required by state statutes to agree to my requested restrictions, unless in extenuating circumstances allowed by law.

By signing this form, I consent for Dr. Linda Comin Psychologist Inc. 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, Dr. Linda Comin Psychologist Inc. may decline to provide treatment to me.

Signature of Patient or Legal Guardian Date

_____ _____

Print Name of Patient

_____

Staff Member Signature

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