HIPAA RELEASE AND CONSENT FORM

Patient Consent for Use and Disclosure of Protected Health Information

_____ I hereby give my consent for Mirashift to use and disclose protected health information (PHI) about me or my child to carry out treatment, payment, and health care operations (TPO). I have the right to review the Notice of Privacy Practices prior to signing this consent. Mirashift reserves the right to revise its Privacy Notice at any time.

With this consent, Mirashift may contact me in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, payments, patient statements and any call pertaining to my clinical care may:

Please check:

☐ Call or text my cell phone

☐ Call my home or other alternative location and leave a message on a voice mail

☐ Email me

☐ Send to my physical address

I have the right to request that Mirashift restrict how it uses or discloses 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.

Your Signature: _____ Date: *(mm/dd/yr)* _____ - _____ - _____

By signing this form, I consent to allow Mirashift to use and disclose my or my child's PUI 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, Mirashift may decline to provide treatment.

Signature of Legal Guardian: _____ Date: *(mm/dd/yr)* _____ - _____ - _____

Print Patient Name: _____

Print Guardian Name: _____