MICHAEL A. FREEDMAN, D.O.

I am familiar with the **Privacy Act** and I accept the terms and conditions of this consent. Please note if you are not familiar with the Privacy Act Laws, you may obtain a copy at the office at the time of your visit.

By refusing to sign this consent or revoking this consent, Dr. Michael Freedman and/or his staff may refuse to treat me as permitted by Section 164.506 of The Code of Federal Regulations.

Print Patient Name _____
Last First Middle

Signature of Patient, Parent or Guardian _____ _____
DATE

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I do hereby authorize Dr. Michael Freedman and the staff to discuss my lab or test results, referrals, medication requests, telephone inquiries, financial and billing information as well as any treatment relating to myself with the friends and/or family members listed below.

_____
Name Relationship

_____
Name Relationship

I wish to be contacted in the following manner:

Home Telephone (Please check one)_____
TELEPHONE NUMBER

- ☐ **It is permissible to leave a message with detailed information.**
- ☐ **Please leave a message with a callback number only.**

Work Telephone (Please check one) _____
TELEPHONE NUMBER

- ☐ **It is permissible to leave a message with detailed information.**
- ☐ **Please leave a message with a callback number only.**

Written Communication(Please check all that apply) _____
ADDRESS - HOME OR WORK

- ☐ **It is permissible to mail documents to my home address.**
- ☐ **It is permissible to mail documents to my work/office address.**

********** OFFICE USE ONLY **********

Updated_____ _____
SIGNATURE DATE

Updated_____ _____
SIGNATURE DATE

DOCUMENTATION OF FAILURE TO OBTAIN SIGNED ACKNOWLEDGEMENT:

On _____/_____/_____ I, _____presented this Acknowledgement of Receipt of

Form to _____. The patient refused to provide a signature when requested.

PATIENT CONSENT FORM

Dr. Michael A. Freedman

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent of Dr. Freedman to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operation (TPO). (The disclosure Notice of Privacy Practice provided by Dr. Freedman describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Freedman reserve 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 Michele P. 14600 King Road, Suite D, Riverview, MI 48193.

With this consent, Dr. Freedman may call my home or other alternative location and 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 calls pertaining to my clinical care, including test results, among others.

With this consent, Dr. Freedman may send appointment reminders cards and patient statements. I have the right to request that Dr. Freedman 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.

By signing this form, I am consenting to allow Dr. Freedman 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, Dr. Freedman may decline to provide treatment to me.

Signed by: _____ _____ _____

Signature of Patient/Legal Guardian | Date | Relationship to Patient

_____ _____ _____

Print Patient's Name | Print Name of Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of the authorization form.