Sparks Family Medicine, LTD

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Protected Health Information Consent Form

To comply with state and federal law concerning the disclosure of protected health information (PHI), Sparks Family Medicine, Ltd. requires that you indicate how PHI should be communicated to you or your personal representative. Please choose one of the following:

- ☐ PHI, (including lab results, imaging studies, results from specialist visits), MAY BE COMMUNICATED BY PHONE, PHONE MESSAGE AND/OR EMAIL. I would like for treatment results to be phoned to the following number and/or email provided by me. I understand that the information disclosed will be minimal, such as first name, the name of our office, results of either "normal" or "abnormal," basic treatment result data, (e.g., cholesterol levels) and our office telephone number.
  - ☐ Phone Number: _____
  - ☐ Email Address: _____
- ☐ PLEASE **DO NOT** COMMUNICATE PHI TO ME BY PHONE OR EMAIL. I will make follow-up appointments to receive treatment results in person. I understand that this appointment will be treated as any other appointment, with payment, i.e. co-payment, deductible, patient responsibility, due at time of service.
- ☐ PLEASE SHARE MY PHI WITH THE FOLLOWING INDIVIDUALS:

  _____

  _____

Your rights as outlined in the Notice of Privacy Practices provided to you by this office are still protected, regardless of how you chose for PHI to be communicated to you or your personal representative. This consent form will remain in effect unless changed, in writing, by you or your personal representative.

*Please note that any **analysis** of treatment results **will** require an appointment.*

Patient (Print): _____ Date: _____

Signature _____ _____
Patient/Parent/Guardian Printed Name of Parent/Guardian