EmergeOrtho

Consent to Use OR Disclose Information For Treatment, Payment or Health Care Operations

The patient or legally authorized guardian hereby consents to the use of his/her individually identifiable health information ("protected health information") by EmergeOrtho in order to carry out treatment, payment or health care operations. The patient should review EmergeOrtho Notice of Privacy Practices for Protected Health Information (Notice) for a more complete description of the potential uses and disclosures of such information. The patient has the right to review such Notice Prior to signing the consent form.

EmergeOrtho reserves the right to change the terms of Notice of Privacy Practices for Protected Health Information (Notice) at any time. If EmergeOrtho does change the terms of its Notice, the patient may obtain a copy of the revised Notice.

Patients retain the right to request that EmergeOrtho further restrict how his/her protected health information is used or disclosed to carry our treatment, payment, or health care operations, EmergeOrtho is not required to agree to such requested restrictions; however, if EmergeOrtho does agree to Patient's requested reaction(s), such reactions are then binding on EmergeOrtho.

EmergeOrtho may communicate electronically to a patient as long as our organization provides reasonable safeguards. Our office makes every attempt to protect a patient's Private Healthcare Information (PHI). Patients have the right to initiate communication via electronic messaging to your healthcare provider. However, external email communication is not encrypted. If you prefer additional safeguards or encrypted messaging, please use EmergeOrtho's portal, https://847.portal.athenahealth.com/ through fax or via phone call to the office.

The patient retains the right to revoke this Consent. At all times such revocation must be submitted to EmergeOrtho in writing. The revocation shall be effective except to the extent that EmergeOrtho has already taken action in reliance on the Consent.

EmergeOrtho may refuse to treat patient if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that EmergeOrtho is required by law to treat individuals). If patient (or authorized representative) signs this consent form and then revokes Consent, EmergeOrtho has the right to refuse to provide further treatment to patient as of the time of revocation (except to the extent that EmergeOrtho is required by law to treat individual).

I authorize release of my medical information to the following companies, individuals and/or school system:

Name	Relationship	Telephone number
Name	Relationship	Telephone number
Name	Relationship	Telephone number
School	Athletic Trainer/Coach	Telephone number

Additionally, I consent to treatment necessary for the care of the below named person for whom I am legally responsible. I authorize the release of all medical records to the referring or primary care physicians, or to other physicians as required for treatment and to my health insurance company, if applicable. Lastly, I acknowledge my consent to release Medical Records and/or information to my dependents/child's school, athletic trainer and/or coach in an effort to coordinate sports or physical activity. I authorize transmission of medical information by fax. I authorize my health insurance company to utilize the medical information as reasonably necessary for the proper administration of the health plan. I also acknowledge full financial responsibility for services rendered by EmergeOrtho.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY AD I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

I authorize the release of medical information to insurance carriers and authorize insurance payment directly to EmergeOrtho. I also understand that my physician may need access to my medication history and may work in conjunction with my pharmacy and/or insurance carrier in order to provide accurate medical treatment. I am responsible for all of my co-pay charges and those charges denied or determined non-covered by my insurance.

PATIENT'S DOB_____ PRINTED NAME_____

LEGAL GUARDIAN_____ SIGNATURE & DATE _____

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Please indicate by initialing the box that you authorize EmergeOrtho to communicate with you via e-mail and also with, third parties, such as, physicians, nurse case managers, insurance companies and adjusters and employers. E-mail cannot be guaranteed to be a secure or error free transmission, as information could be intercepted, corrupted, lost, destroyed.