NORTHPORT
WELLNESS CENTER
Your Path to Optimal Health

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Dr. Lawrence Palevsky, MD, Dr. Francesca Farinacci, MD MPH and staff of Holistic Child Health (HCH), may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Palevsky, Dr. Francesca Farinacci, MD MPH and the HCH reserve the right to revise its Notice of Privacy at any time.

PLEASE INITIAL EACH ITEM THAT YOU WANT TO ALLOW US TO DO.

PLEASE CROSS OUT EACH ITEM (ENTIRE SENTENCE) THAT YOU DO NOT WANT TO ALLOW US TO DO. (If any one item within the sentence is a no, then the whole number is no).

With this consent, Dr. Palevsky, Dr. Francesca Farinacci, MD MPH and the HCH Staff may:

1. Call my home or cell phone 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, normal test results and return calls requesting a call back.
2. At any alternative location will only leave a message on my personal voice mail or in person in reference to any item that assists the practice in carrying out TPO, such as appointment reminder cards and any calls pertaining to my clinical care. However, at any alternative location call, Dr. Palevsky and the HCH staff will not leave a message about my medical condition or lab results with any other person.
3. Dr. Palevsky and the HCH staff also have my permission to fax to and receive faxes from other providers, items that assist the practice in carrying out TPO.
4. May mail to my home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and Patient statements as long as they are marked Personal and Confidential.
5. May e-mail to my home or other alternative location any items that assist in the Practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Dr. Palevsky, Dr. Francesca Farinacci, MD MPH and the HCH staff restrict how it uses or discloses PHI to carry out TPO. However, 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 Dr. Palevsky, Dr. Francesca Farinacci, MD MPH and the HCH staff's use and disclosure of 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. Palevsky and or Dr. Francesca Farinacci, MD MPH may decline to provide treatment to me.

If you have any questions about our Notice of Privacy Practices, please call the Northport Wellness Center at 631-262-8505.

_____Date_____

Print Patient's Name Patient's Signature

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Print Name of Legal Guardian Legal Guardian's Signature