Kate's Corner Osteopathic Care, PLC
Katherine A. Worden, DO, FAAO

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HIPAA Patient Consent Form

Patient's Name _____ Date _____

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law.

I hereby give my consent for Kate's Corner Osteopathic Care, PLC to use and disclose protected health information (**PHI**) about me to carry out treatment, payment and healthcare operations (**TPO**). (Kate's Corner Osteopathic Care's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. The practice reserves the right to revise its Notice of Privacy Practices at Kate's Corner Osteopathic Care, PLC anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Kate's Corner Osteopathic Care, PLC, Privacy Officer
6615 W. Misty Willow Ln, Glendale, AZ 85310
or by accessing it on the website: www.katescornerosteopathic.com

With this consent, Kate's Corner Osteopathic Care, PLC 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 laboratory results among others.

With this consent, Kate's Corner Osteopathic Care, PLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Kate's Corner Osteopathic Care, PLC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Kate's Corner Osteopathic Care, PLC 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 Kate's Corner Osteopathic Care, PLC'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, or later revoke it, Kate's Corner Osteopathic Care, PLC may decline to provide treatment to me.

Signature of Patient or Legal Guardian _____

Print Name of Patient or Legal Guardian _____