Mobile Physical Medicine
& Wellness, PC

CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

I AUTHORIZE Mobile Physical Medicine & Wellness, P.C. to perform medical treatment.

I CONSENT to Mobile Physical Medicine & Wellness, P.C. use and disclosure of all individually identifiable personal, health, financial and demographic information (known as Protected Health Information or PHI) for the purposes of:

- Providing medical treatment
- Obtaining payment and reimbursement
- Obtaining authorizations from my insurance
- Requesting healthcare services from other providers
- Cooperating with other providers in my medical treatment
- Fulfilling requests for information when specifically authorized by me
- In addition, doing all other things directly related to providing healthcare to me (messages, reminders)

The above purposes and all other uses are known collectively as Treatment, Payment and Other Healthcare Operations or TPO and this information may include or be related to psychiatric or psychosocial impairments, substance abuse, human immunodeficiency virus (HIV), HIV-related opportunistic infection, or pregnancy. You may review or receive a copy of our entire Notice of Privacy Practices upon request.

I AUTHORIZE any physician or healthcare facility to provide upon request any PHI to Mobile Physical Medicine & Wellness, P.C. when needed for the purpose of TPO.

I CONSENT to Mobile Physical Medicine & Wellness, P.C. discussing any or all of my medical care including my evaluation, treatment, diagnosis even if related to psychiatric or psychosocial impairments, substance abuse, human immunodeficiency virus (HIV), HIV-related opportunistic infections, or pregnancy with the following personal contact(s).

1. _____ Relationship: _____ Phone: _____
2. _____ Relationship: _____ Phone: _____
3. _____ Relationship: _____ Phone: _____

I have been given the opportunity to review and agree with the terms and conditions of Mobile Physical Medicine & Wellness, P.C.'s Patient Information Protection Plan.

I understand my rights to restrict the use and disclosure of PHI and to revoke this consent at any time in writing.

I understand that should I choose not to consent to the terms and conditions of Mobile Physical Medicine & Wellness, P.C.'s Patient Information Protection Plan, the practice has the right to and will withhold treatment except where required by law.

PATIENT NAME (please print) _____

PATIENT'S SIGNATURE _____ DATE: _____

GUARDIAN'S SIGNATURE _____ DATE: _____

The Health Insurance Portability and Accountability Act of 1996 prohibits the use and disclosure of protective health information for treatment, payment, and other healthcare operations without a signed consent and prohibits the use and disclosure of protective health information for non healthcare related activities without specific and explicit authorization.