PLASTIC SURGERY INSTITUTE OF OHIO

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Patient consent for use and disclosure of protected health information: Authorization for billing, claims for submission, release of information for referrals, precertification's, prior authorizations and TPO (treatment, payment and healthcare operations). I understand that as part of my healthcare, this practice originates and maintains health records describing my health, history, symptoms, examination, test results, diagnosis, treatment and any plans for future care or treatment. A basis for planning my care; A means of communication among the many health professionals who contribute to my care; A source of information for applying my diagnosis and surgical information to my bill; A means by which a third-party payer can verify that services billed were provided and A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I am also giving consent to Dr. Jared Storck, to call my home or other designated locations and leave a message on my voicemail, in person or email about any items that assist the practice in carrying out TPO; insurance items, clinical care or lab results. I understand that information concerning testing, care, treatment or diagnosis for HIV/AIDS and/or chemical/drug/alcohol dependency may be in my medical record. I understand that this information is part of my medical record and may be related to Medicare and/or my insurance company for processing healthcare claims.

I authorize the holder of medical or related information about me, to release to HFCA (Health Care Financing Administration) and/or my insurance company about my healthcare, medical condition or related concerns by means of claim form, copies of medical records, faxed or phone call. I further understand and agree to pay for services or amounts due when appropriate. Theses charges could include amounts applied to my deductible, co-payments, and charges denies as not covered by my insurance program or deemed medically necessary.

I have the right to request that Dr. Jared Storck restrict how he uses or discloses my PHI (Protected Health Information) to carry out TPO. This practice is not required to agree to my requested restrictions but if it does is bound by this agreement. By signing this form, I am consenting to Dr. Jared Storck to use and disclose my PHI to carry out my TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures upon my prior consent. If I do not sign this consent, Dr. Jared Storck may decline to provide treatment to me. I fully understand and accept the terms of this consent. I have been provided with a Notice of Privacy Practices that provides a more complete description of information and disclosures. I wish to have the following restrictions to the use or disclosure of my health information:

Signature of Patient/Legal Guardian ____

Patients Name ____________________________ Date ______________________________