

Patient Consent Form

Jonesboro Clinic
Daniel B. Bennett, M.D.

Patient Consent for Use and Disclosure Of Protected Health Information

I hereby give my consent for Dr. Bennett to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). The Notice of Privacy Practices provided by Dr. Bennett describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Bennett reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Jonathan Bennett, 1811 Executive Square Jonesboro, AR 72401.

With this consent, Dr. Bennett or any of his employees, may call my home or other alternative location and leave a message on voicemail 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 test results, among others.

With this consent, Dr. Bennett or any of his employees, 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 as long as they are marked "Personal and Confidential."

With this consent, Dr. Bennett or any of his employees, 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 Jonesboro Clinic restrict how it uses or discloses my PHI to carry out TPO in writing. 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 allow Jonesboro Clinic to use and disclose my PHI to carry out TPO. I may revoke my consent in writing 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, Dr. Bennett may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Print Patient's Name

Date

Print Name of Patient or Legal Guardian, if applicable.