Kathy E Wolf MD PC
Bringing hope through compassionate healthcare

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for the practice of **Kathy Wolf, M.D., PC** 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 **Kathy Wolf, M.D., PC** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Kathy Wolf, M.D., PC** 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 **Kathy Wolf, M.D., PC.**

With this consent, the practice of **Dr. Kathy Wolf, M.D., PC and all its employees** 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 test results, among others.

With this consent, **Kathy Wolf, M.D, PC** 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, the practice of **Dr. Kathy Wolf, M.D., PC and all its 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 **Kathy Wolf, M.D., PC** 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 allow the practice **Kathy Wolf, M.D., PC** to use and disclose 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, **Kathy Wolf, M.D.** may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Print Patient's Name Relationship to Patient