HOME ON THE RANGE

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Home On The Range may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Home On The Range's Notice of Privacy Practices for 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. Home On The Range 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 HOTR Privacy Officer at 16351 I94, Sentinel Butte, ND 58654.

With my consent, Home On The Range may call my home or other designated 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 messages, permission slips, insurance items, and any call pertaining to my clinical care, including laboratory results, among others.

With my consent, Home On The Range may mail to my home or other designated location any items that assist in carrying out TPO, such as progress reports, permission slips, and patient statements, as long as they are marked Personal and Confidential.

With my consent, Home On The Range may email to my home or other designated location any items that assist the practice in carrying out TPO, such as progress reports, permission slips, and patient statements. I have the right to request that Home On The Range restrict how it uses or discloses my PHI to carry out TPO. However, the facility is not required to agree to my requested restrictions, but it if does, it is bound by this agreement.

By signing this form, I am consenting to Home On The Range, use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing to the extent that the facility has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Home On The Range may decline to provide treatment to me.

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Patient's Name

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Signature of Patient or Legal Guardian **Date**

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Printed Name of Patient or Legal Guardian