RIFE & ASSOCIATES
FAMILY HEALTH CARE

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Dr. Rife & Associates Family Medicine ("the practice") may use and disclose protected health information (PHI) about myself to carry out treatment, payment, and healthcare operations (TPO). Please refer to our 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 before signing this consent.

Dr. Rife & Associates Family Medicine 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 Robert Rife, Director of Operations, Dr. Rife & Associates Family Medicine, 10755 163rd Place, Orland Park, Illinois, 60467.

With my consent, the practice may mail to my home, or other designated location, any item(s) that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that the practice restricts how it uses/discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

With my consent, and in accordance with Illinois law, Dr. Rife & Associates Family Medicine staff may call my home or other designated location and leave a message on voicemail, by text, or in-person to myself or any individual I list below to share my personal health information with, in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and anything pertaining to my clinical care, including test results.

By signing this form, I am consenting to the practice's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the consent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the practice may decline to provide treatment to me.

Information Sharing: Please list any individuals that we can share your personal information with other than healthcare providers. (ex. Parents, spouse, friends, etc.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ Please check box if you do not want your personal information shared with anyone.

☐ Please check box if you do not want to be contacted by text

_____ _____
Patient/Guardian Signature Date

_____
Patient/ Guardian Name (Please Print)