Arthritis Consultants, P.A.

Patient Consent Form

In April of 2003, a new federal requirement regarding privacy of information for health care patients took effect. H.I.P.P.A., the Health Insurance Portability and Protection Act requires that all medical providers, insurance companies, and others put in place controls to ensure that your personal medical information is safe.

Arthritis Consultants (A.C., P.A.) requests that each patient sign this consent form which allows us to share protected health information with other physician's offices, your hospital, and insurance company(s). By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

____________________________________ ______/______/________

Patient Name   Date of Birth

____________________________________ ______/______/_______ ____________________________

Signature of Patient or Representative   Date   Relationship to Patient

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents, or others to call and request results of tests and procedures or general information regarding your care. Also, you may require this individual to pick up samples or prescriptions on your behalf. Under the requirements for H.I.P.P.A., we are not allowed to provide this information to anyone without the patient's consent. If you wish to have this information released to others you must sign this form. Signing this form will only give consent to the individuals indicated below. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

1. ____________________________________ Relationship: ________________________
2. ____________________________________ Relationship: ________________________
3. ____________________________________ Relationship: ________________________
4. ____________________________________ Relationship: ________________________

____________________________ ____________________________ ______/______/______

Patient Name   Patient Signature   Date

Authorization to Leave Messages with Household Members/Answering Machine

From time to time it is necessary for a representative of Arthritis Consultants, P.A. to leave messages for patients. The purposes of these messages are to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss lab or procedure results, or to ask a patient to call A.C., P.A. regarding an issue or concern. At no time will a representative of A.C., P.A. discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household and/or on your answering machine. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

____________________________ ____________________________ ______/______/______

Patient Name   Patient Signature   Date