DR. WILHELMSEN & ASSOCIATES, P.A.
7505 OSLER DRIVE, SUITE 403
BALTIMORE, MD 21204

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

DUE TO THE NEW FEDERAL PATIENT CONFIDENTIALITY LAWS (HIPAA), OUR OFFICE WILL NEED YOUR CONSENT IN ORDER TO TREAT YOU.

We use information that you provide to us, including health information, to carry out treatment, payment and health care operations. Please refer to our 'Notice of Privacy Practices' for a more complete description. You have the right to review the notice before signing this consent.

The terms of our Notice of Privacy practices may change. You may obtain a revised notice from our receptionist or by calling our office manager at 410-823-3885.

You have the right to request that we restrict the use of your health information to carry out treatment, payment or health care operations. We are not required to agree to the restriction. If we do agree to any restriction, the agreement is binding on us.

You have the right to be notified following a breach of unsecured PHI (Protected Health Information). You have the right to restrict certain disclosures of PHI to a health plan when you pay out of pocket in full for a health care item or service.

Other uses and disclosures not otherwise described in the Notice of Privacy Practices will be made only with authorization from the patient. Most uses and disclosures of patient information for marketing purpose will require the patient's authorization.

You have the right to revoke this consent at any time by notifying us in writing. The revocation will not have any effect on any actions taken in reliance on the consent prior to the time you revoke it.

EXAMPLES OF WAYS IN WHICH PRIVATE INFORMATION MAY BE USED:

1. Confirm appointments for patients.
2. Leave messages with anyone or on your answering machine, voice mail, etc.
3. Leave lab results with anyone or on your answering machine, voice mail, etc.
4. Speak with other physicians in regard to the treatment of our patients.
5. Correspondence with insurers (i.e. health, disability, etc), banking and finance companies and credit card companies.

I HEREBY CONSENT TO THE USE AND DISCLOSURE OF MY INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS PURPOSES.

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(Patient's Name – Please print) (Date)

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SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE

9/13 revised