Ohio Psychiatry Specialists
4807 Rockside Rd. Ste. 300
Independence, OH 44131
P. 216.503.9489
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PRIVACY CONSENT FORM

(This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.)

I hereby give my consent to OHIO PSYCHIATRY SPECIALISTS, LLC to use and disclose my protected health information for the purpose of treatment, payment and operations of my health care and this practice.

Consent for treatment: I, with my signature, authorize OHIO PSYCHIATRY SPECIALISTS, LLC and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but limited to) preventive, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for release of information for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I acknowledge that my provider may use an electronic medical record and transmit information electronically. I further consent to the use for any practice operational needs as identified in the practice privacy notice.

Consent related to the Privacy Notice: I have had a chance to review the Practice Privacy Notice as part of the registration process. I understand that the terms of the Privacy Notice may change, and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my Protected Health Information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but the practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that OHIO PSYCHIATRY SPECIALISTS, LLC may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services. Revoking the consent must be done in writing. If I revoke this consent, the revocation does not take effect until the practice receives the written revocation.

Consent for assignment of benefits: I consent to assign all payments for these services to Ohio Psychiatry Specialists, LLC. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by the payment sources, as required by my contracts with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services.

It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

_____	_____	_____
Patient/Guardian signature	Name printed	Date

Revocation

I hereby revoke the consent given above:

_____	_____
Patient/Guardian	Date