REVIVE
PROACTIVE HEALTH

Please Sign and Fax to Revive

Most patients are very anxious to hear the results of their lab tests or other determinations made by our medical staff regarding their treatment. Due to a physician's schedule, communication of the results, especially if they are within normal ranges, is sometimes delayed. Although all *Revive Proactive Health* personnel, both professionals and non-professionals, are part of the Health Care Operations of the practice, and therefore do not require a specific HIPAA consent form, *Revive Proactive Health* takes the confidentiality of your personal health information very seriously and does not permit its personnel who are not directly involved in your medical assessments and treatment with access to your medical records without your written consent. By signing this form, you will give permission to allow your *Revive Proactive Health* advisor, or other administrative staff member, to communicate to you via phone, email, in writing, or in person, protected health information pertaining to your medical care.

This consent form does not allow *Revive Proactive Health* to share your health information with any third-party for any reason. It simply authorizes our administrative staff to convey information from our medical staff to you, at your request. I further understand that administrative staff cannot answer specific questions about the meaning of the results or treatment modalities, and if I have such questions after receiving the results, the administrative staff will have a physician or other qualified health professional contact me to answer my questions.

Authorization for *Revive* to Release Health Information to Myself

I, the undersigned patient, hereby give my consent for *Revive Proactive Health* and its non-medical professional and administrative staff to disclose my protected health information (PHI) to me pertaining to my medical results and treatment.

With this consent, my Revive advisor, or other administrative staff, may communicate to me by phone, email, in writing, or in person, information that assists the practice in carrying out operations related to my treatment; such as, appointment reminders, billing issues, and communications related to my clinical care, including laboratory test results. I acknowledge that such advisor or staff cannot answer specific questions about the results or course of my treatment, and that I can request a physician or other health professional to contact me to answer my questions.

I understand that I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. I understand that this form is not required under the HIPAA privacy rule, but if I choose not to consent, or later revoke consent, *Revive Proactive Health* may be unable to continue to provide treatment to me, but they will not do so without affording me a reasonable time, not longer than thirty days, to obtain a successor physician/practice.

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Patient's Signature_____

Patient's Printed Name_____ Date_____

www.revivehrt.com
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