Date: _____

Paul S. Worrell, D.O., P.A.

Patient Consent for Use and Disclosure
Of Protected Health Information

With my consent, Paul S. Worrell, D.O., P.A. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Paul S. Worrell, D.O., P.A.'s Notice of Privacy Practice for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Procedures prior to signing the consent. Paul S. Worrell, D.O., P.A. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Paul S. Worrell, D.O., P.A. Privacy officer at 8668 Skillman Street, Dallas, Texas, 75243.

With my consent, Paul S. Worrell, D.O., P.A. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

Phone # _____ Fax # _____

With my consent, Paul S. Worrell, D.O., P.A. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

Address: _____.

With my consent, Paul S. Worrell, D.O., P.A. may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Paul S. Worrell, D.O., P.A. restrict how it uses or 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.

Email Address: _____.

By signing this form, I am consenting to Paul S. Worrell, D.O., P.A.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent. IF I DO NOT SIGN THIS CONSENT, PAUL S. WORRELL, D.O., P.A. MAY DECLINE TO PROVIDE TREATMENT TO ME.

_____ _____
Print Patients Name Patient's Signature

_____ _____
Signature of Patient's Legal Guardian Print Name of Patient's Legal Guardian

_____
Date

**** Please DO NOT forget to SIGN and DATE this form.***