LOUISIANA HEALTHCARE ASSOCIATES, LLC

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With your consent, **Louisiana Healthcare Associates, LLC** may use and disclose protected health information (PHI) about you to carry out treatment, payment and health care operations (TPO). Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures. You have the right to review our Notice of Privacy Practices prior to signing this consent. We reserve the right to revise our Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our office manager at 71207Highway 21, Covington, LA. 70433

With your consent, **Louisiana Healthcare Associates, LLC** may call your home or office and leave a message in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any calls pertaining to your clinical care.

With your consent, **Louisiana Healthcare Associates, LLC** may mail to your home or office any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements.

You have the right to request that we restrict how we use or disclose your PHI to carry out treatment, payment and healthcare operations. However, we are not required to agree to your requested restrictions, but if we do, we are bound by our agreement.

By signing this form, you are consenting to our use and disclosure of your PHI to carry out treatment, payment and healthcare options. This consent may be revoked in writing except to the extent that we may have already made disclosures in reliance upon your prior consent. If you decline to sign this consent we may decline to provide treatment for you.

Name of person or persons we have permission to discuss your medical care and financial responsibility with

NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER

Print Patient's Name: _____ Date: ____/____/____

Signature of Patient or Legal Guardian: _____