Arthritis & Osteoporosis Associates, LLP.

Consent for Use and Disclosure of Health Information:

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (check all that apply)

___ Home Telephone: ____________________
____Leave a detailed message
____ Leave a message with call back number only

___ Written Communication:
___ Mail to home address
___Mail to work/ office address

___Fax to this number: ____________________

___Work Telephone: ____________________
___ Leave a detailed message
___Leave a message with call back number only

__ Other: (spouse,child,etc.)
(Please list names of individuals we have consent to speak with regarding your care)

____

____

____

Acknowledgment of Receipt of Notice of Privacy Practices:
You have the right to read our Notice of Policy Practices before you sign this consent. Our notice provides description of our treatment, payment activities and healthcare operations, and the uses and disclosures we may make of your protected health information, and of other important information concerning your protected health information. A copy of our Notice is available in our office. We reserve the right to change our privacy practices as described in our Notice. If we change our privacy practices, we will make a copy of the revision available. Which will contain the changes.
AGREEMENT AS TO GOVERNING LAW AND FORUM:
The Patient and healthcare provider rendering or providing health care to patient agree: (1) that all health care rendered shall be governed exclusively and only by Texas Law and in no event shall the law of any other state apply to any healthcare rendered to patient: and (2) in the event of a dispute any lawsuit, action of cause action which in any way relates to the healthcare provided to patient shall only be brought in a Texas District Court in the county of where all or substantially all of the healthcare was provided or rendered and in no law and forum selection provisions of this paragraph are mandatory and are not permissive.
By signing this form, you will consent to the use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

SIGNATURE: ________________________________ DATE:________________
(PATIENT OR PERSONAL REPRESENTATIVE)

PRINT NAME: ____

RELATIONSHIP TO PATIENT (if signed by personal representative):____________________