THE YAKES VASCULAR MALFORMATION CENTER

HIPAA - PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients' Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care options. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made based on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

THE PATIENT UNDERSTANDS THAT:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Yakes Vascular Malformation Center has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
- The Yakes Vascular Malformation Center reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by _____

Printed Name: Patient or Representative

_____ _____

Signature Date

_____

Relationship to Patient (if another than patient)

501 East Hampden Avenue, Suite 4600
Englewood, CO 80113
Phone: 303-788-4280 | Fax: 303-788-4412
info@yakesvascularmalformationcenter.com

THE YAKES VASCULAR MALFORMATION CENTER

AUTHORIZATION TO VERBALLY DISCUSS HEALTH INFORMATION

Today's Date _____

Patient Name_____Date of Birth_____

Phone - Home _____Work _____Cell _____

Address_____City_____State_____Zip Code_____

Email Address _____

I give permission to the Yakes Vascular Malformation Center to verbally discuss the following medical and billing information (Check all boxes that apply):

- ☐ Scheduling and Appointment Information
- ☐ Medical Information – Symptoms, Diagnosis, Medications, and Treatment Plan
- ☐ Lab Results, Test Results, and Imaging Results
- ☐ Billing and Payment Information
- ☐ Other: _____

The Yakes Vascular Malformation Center has permission to discuss the above information with:

Name_____Relationship_____

Address_____

Primary Phone_____Secondary Phone_____

Email _____

Name_____Relationship_____

Address_____

Primary Phone_____Secondary Phone_____

Email _____

X_____ _____

Signature of Patient **Date**

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PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

Today's Date _____

Patient Name_____Date of Birth_____

I consent for medical photographs to be made of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in medical textbooks or journals as I have designated below. By consenting to these medical photographs, I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I will contact The Yakes Vascular Malformation Center.

By signing this form below, I confirm that this consent form has been explained to me in terms which I understand.

Please choose one of the below:

1) ◯ I consent for these photographs to be used in medical publications, including medical journals, textbooks, and electronic publications. I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

2) ◯ I agree to use of my image for medical records **ONLY**

3) ◯ I **DO NOT** consent to any medical photography

_____(Signature) _____(Date)

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