HARRISON
HealthPartners

Patient Opt-Out Consent Form

I agree to permit Harrison Health*Partners* to request and obtain previous medical records from or forward records to other providers if deemed necessary to provide me with proper care and treatments.

I agree to the release of all my insurance and medical information to other healthcare providers, my insurance company, Medicare or any third-party payer to facilitate healthcare, processing of claims, and audit of payments. I understand that the information released may need to include records regarding HIV/AIDS, sexually transmitted diseases, mental health, and drug and alcohol abuse treatment health information.

I agree to be contacted for routine appointments or follow-up information regarding my care by:

- Phone _____ Initials
- Answering machine/Voice mail _____ Initials

I agree to allow the practice to use and disclose information regarding my care as needed:

- Without restrictions/limits to family and friends _____ Initials
- Restricted/limited to the family and friends listed below _____ Initials

Please list the individuals you wish to participate in your care:
The individuals listed here will be considered the only individuals you wish for us to communicate with regarding your care. If these individuals are not available in an emergency situation, we may need to use our discretion regarding use and disclosure of your medical information.

_____
Name of individual Phone number

_____
Name of individual Phone number

Please list individuals you do not wish to participate in your care (if any):

_____
Name of individual Phone number

_____
Name of individual Phone number

I agree to be contacted regarding treatment options and health-related benefits regarding medical options that may improve my quality of life. _____ Initials

I understand that I am financially responsible for any and all charges my insurance does not cover. I also agree to pay any finance charges or collection fees that should arise from non-payment.

These consents will remain in effect until revoked by me in writing.

_____
Signature of patient or legally authorized individual Date