Triskelion

April 28, 2020

ACKNOWLEDGEMENT AND CONSENT
TO USE/DISCLOSE CLINICAL INFORMATION

I understand that Triskelion (referred to below as "This Practice") will use and disclose health information about me.

I understand that my health information may include information both created and received by This Practice, may be in the form of written, electronic records, or spoken words, and may include information about my health history, health status, symptoms, examination, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care ; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area, and a copy is available online at triskelion.health website. I may ask for a copy to be mailed to me if I am having a tele-health appointment.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and that I understand that This Practice is not required by law to agree to such requests.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to this office. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before your revocation was received, and that we may decline to treat you or to continue treating you if you revoke this consent.

By signing below, I agree that I reviewed and understand the information above and that I have been offered a copy of the Notice of Privacy Practices, or understand I can view or download it at triskelion.health/new-patient-paperwork.

Name of Patient: ____
(Please Print)

By: ____________________________________ Date: ______________
(Signature of patient or of Representative authorized by law)

Description of Representative's Authority: ____

For Office Use Only
Attempt to obtain written acknowledgement of receipt of the Notice of Privacy Practices, but acknowledgment could not be obtained because: ☐ Individual refused to sign ☐ Emergency care ☐ Communication Barrier ☐ Other:________________

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