WEST BROADWAY CLINIC

1701 W. Broadway
Council Bluffs, IA 51501
Phone: 712-256-5600
Fax: 712-256-3440

CONSENT TO TREAT

I consent to the use or disclosure of my protected health information by **West Broadway Clinic, PC** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **West Broadway Clinic, PC.** I understand that diagnosis or treatment of me by the staff of **West Broadway Clinic** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **The West Broadway Clinic** is not required to agree to the restrictions that I may request. However, if **The West Broadway Clinic, PC** agrees to a restriction that I request, the restriction is binding on **The West Broadway Clinic, PC.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **The West Broadway Clinic, PC** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **The West Broadway Clinic, PC** Notice of Privacy Practices prior to signing this document. **The West Broadway Clinic, PC** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **The West Broadway Clinic, PC** The Notice of Privacy Practices for **West Broadway Clinic, PC** is posted in the reception room of **The West Broadway Clinic, PC** and website at westbroadwayclinic.com. This Notice of Privacy Practices also describes my rights and **The West Broadway Clinic, PC** duties with respect to my protected health information.

NOTICE OF PRIVACY PRACTICES **(provide your initials below)**

A._______ (Initials) I have received the Notice of Privacy Practices of the West Broadway Clinic PC.

The West Broadway Clinic, PC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing **The West Broadway Clinic, PC** website, by calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

______________________________________ ______________________________
Signature of **Patient** or Personal Representative Relationship to **Patient** (parent, spouse, self)

______________________________________ _______________ ________________________
PRINT Name of **Patient** Birth Date of **Patient** Social Security Number of **Patient**

Please indicate by check mark approval to leave following information:

- O Appointment Date and Time Reminder
- O Lab/Test Results/ Medication Changes
- O **DO NOT LEAVE MESSAGES OF ANY KIND**

Leave the above indicated on the following numbers:

- O Home Phone ( ) ____________________
- O Cell Phone ( ) ____________________
- O Work Phone ( ) ____________________

Permission to speak to the following individuals regarding Patient care.

____
Name and Relationship to Patient

____
Name and Relationship to Patient

____
Name and Relationship to Patient

____
Name and Relationship to Patient

For Office Use Only

________________________________ ____________________ ________________
Witness MRN Date of Signing