I understand that as a part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity. I consent to such disclosures for these permitted uses, including disclosures via fax or electronic record transmission.

I fully understand and accept the terms of this consent Yes_____ No_____

May we call you to follow-up on how you are feeling? Yes_____ No_____

May we call your home with lab results or results? Yes_____ No_____

If we may call your home, what telephone number should we call?_____

May we leave a message on your answering machine or voice mail? Yes_____ No_____

May we leave a message with the person answering the phone? Yes_____ No_____

May we contact you by e-mail? Yes_____ No_____

If Yes, please provide the e-mail address you wish to be contacted at:

_____

Please list a person we may contact in case of emergency:

Name:_____ Relationship:_____

Phone:_____ Address:_____

Please list others with whom we may discuss your medical care, including family members and other medical providers handling your care:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Signature:_____ Date:_____

For Office Use:

( ) Consent received and added to medical record by _____ on _____

( ) Consent refused by patient and treatment refused and permitted.

North Stonington Medical Walk-In Center P.C
Consent to the Use and Disclosure of Health Information
For Treatment, Payment, and Healthcare Operations

I _____ understand that as a part of my healthcare, North Stonington Medical Center Walk-In Center PC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnoses and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare such as assessing the quality and reviewing the competence of healthcare professionals.

I understand that I have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that the North Stonington Medical Walk-In Center PC, is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that the North Stonington Medical Walk-In Center PC reserves the right to change their notices and practices prior to implementation, in accordance with Section 164.521 of the Code of Federal Regulations. Should North Stonington Medical Walk-In Center, PC change their notice, they will send me a copy of any revised notice to the address I've provided (whether by US mail, or, if I agree, e-mail).

I wish to have the following restrictions to the use or disclosure of my health information.

_____

_____

_____