INJURY SOLUTIONS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations within the parameters of the Notice of Privacy Practices.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices. Our Notice provides a description of our treatment, payment activities, healthcare operations, other uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read our Notice of Privacy Practices brochure carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting Injury Solutions:

Telephone: 720-282-4707
Email: Info@InjurySolutions.md
Mailing Address: 7350 E Progress Place Suite 201 Greenwood Village, CO 80111

Phone Contact: We may utilize phone numbers you have provided us to contact you as necessary. It is:
☐ Okay ☐ Not Okay to leave messages on my answering machine.
☐ Okay ☐ Not Okay to leave messages with any other person.

Name: _____

E-Mail Contact: We may utilize email addresses you have provided us to contact you as necessary. It is:
☐ Okay ☐ Not Okay to contact me via email _____

Fax Contact: We may utilize a fax number you have provided us to contact you as necessary. It is:
☐ Okay ☐ Not Okay to contact me via fax _____

Additions: Is there anyone else involved in your care, or payment of your care with whom we may share your information?
☐ Yes ☐ No

If Yes.: _____
Name: Phone:

Exclusions: Is there someone that you specifically DO NOT want us to share information with?
☐ Yes ☐ No

If Yes: _____
Name: Phone:

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 the contact persons stated above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation. Please understand that we may decline to continue to treat you or to continue treating you if you revoke this consent.

I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent, I am giving my consent to use and disclose of my protected health information to carry out treatment, payment activities and health care operations.

☐ I have received a copy of the offices Notice of Privacy Practices.

☐ I decline a copy of the Notices of Privacy Practices.

Signature: _____ Date: _____

Revised 02.07.2022