SIMMONDS, MARTIN & HELMBRECHT
WE LISTEN, WE TEACH, WE CARE
AN ADVANTIA HEALTH PRACTICE

PATIENT CONSENT FORM

By signing this form I acknowledge that I have received and/or been given an opportunity to read a copy of the patient Notice of Privacy Practices, and my signature acknowledges my understanding.

1. May we leave messages on your voicemail regarding the following?
   - Scheduling or Appointment Information YES ______ NO _______
   - Detailed Medical Information YES ______ NO _______
   - Billing, Insurance or Claim Information YES ______ NO _______
2. May we leave messages with a family member Requesting you to call the office? YES ______ NO _______

Primary Care Physician ____________________________ PCP Practice Name _________________________________

HIPAA Authorization: Please choose **ONE** of the following:

_____ Patient ONLY

I understand that staff at Simmonds, Martin & Helmbrecht may ONLY speak with me; the patient In regards to information about my appointments, treatment, results, insurance, billing & etc…

OR

_____ Simmonds, Martin & Helmbrecht has permission to disclose my medical information to the following:

1. ____ ___________________________
   Please release info to: *Print name* Relationship
2. ____ ___________________________
   Please release info to: *Print name* Relationship
3. ____ ___________________________
   Please release info to: *Print name* Relationship

Patient Name: *(please print)* ____ Date of Birth: _________________

PATIENT SIGNATURE
Or Parent / Guardian if Minor Patient: __________________________________ Date Signed: _________________