CONSENT FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

In our Notice of Privacy Practices (NPP) we provide you information about how the University of Kansas can use or disclose your medical information. As described in our NPP, we request your consent for any use or disclosure of medical information to carry out treatment, payment, or health care operations. You have a right to review our NPP before signing this Consent.

By signing this Consent form, you: (1) Acknowledge that a copy of the NPP has been provided to you; and (2) Consent to our use and disclosure of your health information for treatment, payment, or health care operations, as described in the NPP.

Patient's Name (Printed)_____

Patient's Email _____

Signature of Patient _____ Date:_____

HEALTH INSURANCE POLICY INFORMATION

Insurance Company Name _____

Member ID# _____

Group # _____

Insurance Address

_____

City_____State_____Zip Code_____

Policyholder Name

_____

Policyholder Date of Birth_____Relationship_____❑ Male ❑ Female

(Parent, Spouse, Self)

Policyholder Address

_____

City_____State_____Zip Code_____