Center for Health and Vision

Kenneth L. Malamud, M.D., PLLC
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512-715-3937 512-715-3938 (fax)

PATIENT CONSENT FORM

Use and Disclosure of Protected Health Information
I consent to allow Kenneth L. Malamud, M.D., PLLC and his staff to disclose my Protected Health Information in order to carry out medical treatment, payment and healthcare operations.

Authorization/Insurance Payment
I authorize Kenneth L. Malamud, M.D., PLLC and his staff to provide medical information to my insurance carrier, and I authorize payment of medical benefits to Kenneth L. Malamud, M.D., PLLC for services provided to me.

Authorization to Leave Voice Messages and/or E-mail
I authorize Kenneth L. Malamud, M.D., PLLC and his staff to leave messages by voice or e-mail at my home or employment, reminding me of scheduled medical appointments and other medical services for myself and/or my family members. I understand, however, that ***no message will be left regarding confidential medical information*** unless specifically authorized by my doctor and myself.

By signing this form, I am consenting to Kenneth L. Malamud, M.D., PLLC and his staff to use and disclose my protected medical information as detailed above. However, I may give notice to restrict the use of such information and revoke my consent in writing. I understand that I have the right to review the Notice of Privacy Practices for a more complete description of such uses and disclosures prior to signing this consent.

Financial Responsibility
I accept financial responsibility for all charges for medical care provided to me and/or my family members by the physician and medical staff of the Center for Health and Vision.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Patient's Name (please print)

_____
Name of Legal Guardian (please print)