Christine Tronge, LCSW (BBS #27832)
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Consent to Use PHI for Treatment, Payment, and Healthcare Operations

(Please Bring This Form to Your First Appointment)

With my consent, Christine Tronge, LCSW may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Ms. Tronge's Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Christine Tronge, LCSW reserves the right to revise her Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Ms. Tronge above.

With my consent, Christine Tronge, LCSW may call my cell phone or designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care. With my consent, Christine Tronge, LCSW may mail to my home or other designated location any items that assist in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked Personal and Confidential.

With my consent, Christine Tronge, LCSW may e-mail to me my appointment reminder cards and patient statements. I have the right to request that Christine Tronge, LCSW restrict how she uses or discloses my PHI to carry out TPO. However, the practice is required by State Statutes to agree to my requested restrictions, unless in extenuating circumstances allowed by law.

By signing this form, I consent for Christine Tronge, LCSW to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Christine Tronge, LCSW may decline to provide treatment to me.

Signature of Patient or Legal Guardian Date

_____ _____

Print Name of Patient

_____

Staff Member Signature Date

_____ _____

Print Name of Staff

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