Douglas W. Yoder, M.D., F.A.C.S.
J. I. Alammar, M.D., F.A.C.S., F.I.C.S.

Blanchard Valley Surgical Specialists, Inc.
1725 South Main Street
Findlay, OH 45840
Phone: 419/423-0424 Fax: 419/423-0641

General Surgery – Endoscopy – Laparoscopy – Breast – Melanoma – Thyroid – Colon & Rectal Surgery

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Blanchard Valley Surgical Specialists, Inc. to use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and Health Care Operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Blanchard Valley Surgical Specialists, Inc. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained from a secretary while visiting the office or by forwarding a written request to Blanchard Valley Surgical Specialists, Inc., Privacy Practices, 1725 South Main Street, Findlay, Ohio 45840.

With this consent, Blanchard Valley Surgical Specialists, Inc., may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Blanchard Valley Surgical Specialists, Inc., may call my home or other alternative 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 calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Blanchard Valley Surgical Specialists, Inc. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO. I have the right to request that Blanchard Valley Surgical Specialists, Inc. restrict how it uses or discloses my Protected Health Information (PHI). The practice is not required to agree to my requested restrictions, but if it does, it is bound by the agreement.

By signing this form, I am consenting to allow Blanchard Valley Surgical Specialists, Inc. 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, or later revoke it; Blanchard Valley Surgical Specialists, Inc. may decline to provide treatment to me.

OVER ⟶

HIPPA PATIENT CONFIDENTIALITY

It is the policy of Douglas W. Yoder, M.D. and J. I. Alammar, M.D. to *not* release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voicemail, e-mail, cell phone, cell voicemail and/or pager. Whenever returning calls and the answering machine picks up, we do *not* leave a message if the name or telephone number is not on the recorded message to identify the residence and this will continue to be policy. Information will also *not* be left with an unauthorized person who may answer the telephone.

If you would like to have information released to someone other than yourself, please complete the following.

I authorize Douglas W. Yoder, M.D. and/or J. I. Alammar, M.D. to leave medical information pertaining to my care, by the following methods. I will assume responsibility to notify them if/when this information changes.

Home Telephone ___________________________ _____ yes _____ no Answering Machine _____ yes _____ no

Cell Phone ________________________________ _____ yes _____ no Cell Voicemail _____ yes _____ no

Work Phone _______________________________ _____ yes _____ no Work Voicemail _____ yes _____ no

Pager ____________________________________ _____ yes _____ no

E-mail ___________________________________ _____ yes _____ no

Fax Medical Records for referrals to another Entity (Physician, Insurance, etc.) _____ yes _____ no

Please list the names of the people you authorize to receive message about your personal medical information:

Spouse/Partner: ____

Parent: ____

Other names (and ***please list the relationship***) Phone

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

Additional Comments:

____________________________________ ______________________________________

Print Patient's Name Signature of Patient or Legal Guardian

____________________________________ ______________________________________

Print Name of Legal Guardian (If Applicable) Date