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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, **Electrodiagnostic Medicine & Rehabilitation Specialist, LLC or EMARS** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). I have been given the opportunity to review EMARS's Notice of Privacy Practices for a more complete description of such uses and disclosures prior to signing this consent.

EMARS reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to EMARS – Privacy Officer at 10700 Montgomery Rd., Suite 110, Cincinnati, OH 45242.

With my consent, EMARS may call my home or other 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, including laboratory results among others for treatments today and in the future.

With my consent, EMARS can forward copies, and/or discuss contents, of the Office notes and documents from my evaluations at EMARS, by Ayse L. Lee-Robinson, M.D. to:

1. **Referring physician: Name** _____
Address: _____
Phone/Fax: _____

2. **Primary Care Doctor: Name** _____
Address: _____
Phone/Fax: _____

3. **Other (BWC, etc.): Name** _____
Address: _____
Phone/Fax: _____

With my consent, EMARS may mail to my home or other designated location, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked Personal and Confidential for treatments today and in the future.

I have the right to request that EMARS restrict how it uses or discloses my PHI to carry out TPO now and in the future. I understand I need to complete and file a Request for Limitations and Restrictions of Protected Health Information form with EMARS to exercise this right.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. EMARS will provide a written response to any such requests.

Name of Patient: _____ **Date:** _____

Signature of Patient: _____ **Phone #** _____