Physician Associates of Floyds Knobs, LLC
800 Highlander Point Suite 300
Floyds Knobs, IN 47119
Phone (812) 923-2273 Fax (812) 923-4100

Consent for Use & Disclosure of Health Information

Patient Name: ______________________________ Date of Birth: ___/___/___

Address: ____

Phone: ______-______-______ Cell: ______-______-______

Please read the following statements carefully.

By signing this form, you will consent to our use of your protected health information. Your protected health information will be used only to carry out treatment, payment or healthcare operations, unless otherwise authorized.

You have been given the Notice of Privacy Practices and it is advised that you read these prior to signing this form. This notice will advise you of your rights with respect to your protected health information.

If this notice is amended in any way you will be notified.

Signature: ____________________________________ Date: ____/____/____

If this is signed by a personal representative on behalf of the patient, please complete the following:
Personal Representative's Name: ____________________________________
Relationship to Patient: _____________________ Date: ____/_____/____

Permission - Authorization Form:

This authorization gives your doctor's office permission to disclose your health information, labs, x-rays, appointment information, to the designated person below. This is a "blanket" authorization, if you desire to be more specific please inform us now.

I ____________________________ give the staff and physicians permission to disclose my health information to:

- ☐ My spouse: ____
- ☐ My children: ____
- ☐ Another family member or significant other: _______________________
- ☐ I give permission to leave information on my answering machine or voice mail.