

OGUNRO HAND TO SHOULDER CENTER

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, **Ogunro Hand To Shoulder Center** may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to **Ogunro Hand To Shoulder Center** Notice of Privacy Practices for more complete description of such used and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing the consent. **Ogunro Hand To Shoulder Center** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained in the front office.

With my consent **Ogunro Hand To Shoulder Center** may call my home, answering machine, voicemail, cell phone, or business, and may speak with whom I specified and leave message 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, or may speak to the people specified in in this form in person about my care.

With my consent, **Ogunro Hand To Shoulder Center** may mail, fax to my home or other healthcare facilities any items that assist the practice in carrying out TPO, such as appointment reminders cards, patient statements, chart notes, demographics, etc. With my consent, office may call a pharmacy, with the pharmacist and/or fax.

By signing this form, I am consenting **Ogunro Hand To Shoulder Center** to use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. **IF I DO NOT SIGN THIS CONSENT, Ogunro Hand To Shoulder Center MAY DECLINE TO PROVIDE TREATMENT TO ME.**

Signature of Patient or Legal Guardian

Print Name of Patient or Legal Guardian

Date

List person that we can leave a message with