Connecticut Psychiatric Partners, P.C.
345 N Main St, Ste 311
West Hartford, CT 06117.
Tel: 860-707-3502
Fax: 860-707-2519

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE & CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME :_____**DOB**: _____
E-MAIL ADDRESS: _____
WE WILL NOT SHARE YOUR E-MAIL ADDRESS OR USE IT TO TRANSMIT MEDICAL OR CLINICAL INFORMATION.

1)I Have been offered or received a copy of Connecticut Psychiatric Partners "Notice of Privacy Practice."
☐

2) I give permission for CPP to contact me at the following numbers and to leave a message on my answering machine or voicemail (if not, please leave blank):

MESSAGES CONCERNING APPOINTMENTS Phone (__) _____
Home/ Mobile / Work (circle)

MESSAGES CONCERNING MEDICAL INFO Phone (__) _____
(For example lab or test results) *Home/ Mobile / Work (circle)*

If you provided a mobile telephone number during registration, then I hereby authorize CPP, and its employees, agents, and business associates, to contact me via such mobile phone for any reason, including without limitations, automated notifications and appointments reminders.

I give my permission for CPP to communicate with the following persons regarding my health care:
Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____
This authorization will be valid from this date until written notice of changes and/or cancellations is received in the office of CPP.

3) Assignment of Benefits: I authorize direct payments to CPP or its designated billing agent for services rendered.

Guarantee of Payment/Precertification by Insurer: I will be responsible for payment for all non-covered services. If my health plan does not consider CPP to be a participating provider, I will accept full financial responsibility for payment of incurred charges.

Consent for treatment: I do voluntarily consent to the rendering of such care as the provider and/or medical personnel deem necessary for health and wellbeing. The consent shall include medical examination and diagnostic testing, or I may receive a practice specific consent form. The form may also include the carrying out of orders of my treating provider by office personnel. I acknowledge that neither the provider nor the office personnel has made any guarantee or assurance as to the results that may be obtained. I understand and agree that audio, photographs, videotaped images or other images may be made of me for purposes of medical documentation or education as medical providers and staff deem appropriate.

4) To better provide for you care and enhance your patient experience, we seek to coordinate and integrate our care delivery through our electronic medical record (EMR) which is paperless. We share access to the EMR across the CPP and some other CPP affiliated practices (accessed only as described in the Notice of Privacy Practices).

By signing this authorization form, you understand and agree that you are allowing disclosure of and access to all your health information, including information relating to alcohol and substance abuse/use, mental or behavioral health, and HIV/AIDS. If health information about you includes any of these types of information, you specifically authorize the release of such information to, and access to such information to, and access to such information. You may revoke this authorization at any time except to the extent it has already been relied upon. Unless earlier revoked, this consent will expire if and when CPP EMR no longer exists.

For the sake of confidentiality, we use EMR mainly for prescriptions and billing only. Your appointment records are maintained on paper and that information is not put online, or provided to a third party prior to your consent. If you have any questions, please do not hesitate to ask us about our EMR.

☐ I choose to opt out and by doing so understand I decline to receive care at CPP.

_____
Patient Signature/ Date

_____
Parent or Guardian Signature/ Date
If patient is a minor (under age of 18) or has a guardian/ conservator

this must be signed by the parent or legal guardian.

EMAIL US