Carl E. Thornblade, MD
2801 Great Northern Loop
Missoula, MT 59808

Notice of Privacy Practice Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: ~ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. ~ Obtain payment from third-party payers. ~ Conduct normal healthcare operations such as quality assessments and physician certifications.

Consent for Use and Disclosure of Protected Health Information

With my consent, Carl Thornblade, MD, may use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operation (TPO). Please refer to Carl Thornblade's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that Carl Thornblade 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 the address above .

With my consent, Carl Thornblade may call my home or other designated locations 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.

With my consent, Carl Thornblade may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Carl Thornblade restrict how he uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Carl Thornblade's 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 make disclosures in reliance upon my prior consent. If I do not sign this consent, Carl Thornblade MD may decline to provide treatment to me.

Patient's Name (printed)________________________________ **Date of Birth**_______________

Signature of Patient or Legal Guardian____________________________ **Date**_______________

Printed Name of Legal Guardian____

________________________Office Use Only____________________________

An attempt was made to obtain the patient's signature but unable to do so as documented below:

Date:__________ Initials:__________ Reason: ____________________________________