William P Maier MD PC
Patient Consent For Use and Disclosure of Protected Health Information

- I hereby give my consent for William P Maier MD PC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (William P Maier MD PC's Notice of Privacy Practices provides 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. William P Maier MD PC 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 William P Maier MD PC Privacy Officer at 633 E. 11th Avenue, Eugene, Oregon. 97401.
- With this consent, William P Maier MD PC may call my home or other alternative location that I provide 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 calls pertaining to my clinical care, including laboratory results among others.
- With this consent, William P Maier MD PC may mail to my home or other alternative 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.
- With this consent, William P Maier MD PC may e-mail to my home or other alternative location 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 William P Maier MD PC restrict how it 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 William P Maier MD PC's use and disclosure of my protected healthcare information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, William P Maier MD PC may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian