HIPAA: Health Insurance Portability and Accountability
CONSENT

Christine M. Sciara, M.D., P.C.
1380 Wilmington Pike, Suite 206
West Chester, PA 19382
610-696-1598

With my consent, Christine M. Sciara, M.D., P.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Christine M. Sciara, M.D., P.C.'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.

Christine M. Sciara, M.D., P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Christine M. Sciara, M.D., P.C. Privacy Officer at 1595 Paoli Pike, Suite 105, West Chester, PA 19380.

With my consent, Christine M. Sciara, M.D., P.C. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying to my clinical out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Christine M. Sciara, M.D., P.C. may mail to my home or other designated location any items that assist the practice in carrying TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Christine M. Sciara, M.D., P.C. may e-mail to my home or other designated 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 Christine M. Sciara, M.D., P.C. 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 Christine M. Sciara, M.D., P.C.'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 made disclosures in reliance upon my prior consent. If I do not sign this consent, Christine M. Sciara, M.D., P.C. may decline to provide treatment to me.

Signature_____ Date_____

Patient's Name _____

Print Name of Patient or Legal Guardian _____