PROTECTED HEALTH INFORMATION
ACKNOWLEDGEMENT AND CONSENT

Patient's Name:_____ **Date of Birth:**_____

- I understand that **Todd W Ulmer, MD, PC** (referred to as this "Practice") will use and disclose health information about me. This Practice is in compliance with the HIPAA Privacy Rule and the Federal Trade Commission Red Rule Flags Identity Theft Program.

- I understand that my protected health information may include information both created and received by the Practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

- I understand and agree that this Practice may **use and disclose** my health information in order to:
  - Make decisions about, and plan for, my care and treatment.
  - Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
  - Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care.
  - Perform various office, administrative and business functions that support this Practice's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

- I understand that I have the right to receive and review a written description of how this Practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of protected health information made and the information practices followed by the employees, staff and other office personnel of this Practice, and my rights regarding my health information.

- I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of the Notice of Privacy Practices in effect will be available at my first visit and upon request.

- I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that this Practice is not required by law to agree to such requests.

- I understand that I have the right to revoke this consent and that this must be done in writing.

I request the release of my protected health information to the following individuals:

Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #

By signing below, I agree that I have reviewed and understand ALL the information above.

Signature of Patient or Representative	Date
Relationship	