

Patient Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

**PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our *Notice of Privacy Practices* before you decide whether to sign this Consent. Our Notice provides a description of your treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read our *Notice of Privacy Practices* brochure carefully and completely before signing the Consent.

We reserve the right to change our privacy practices as described in our *Notice of Privacy Practices*. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your health information that we maintain.

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our Notice, at any time by contacting:

Contact Persons: Margo Smith  
 Telephone: 303-328-3400  
 Email: [msmith@nwrasc.com](mailto:msmith@nwrasc.com)  
 Address: 10170 Church Ranch Way #110, Westminster, CO 80021

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, \_\_\_\_\_ (print name) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. This request supersedes any prior request for confidential channel communications I may have made.

**PLEASE SELECT ALL THAT APPLY.**

- Phone:** I want you to contact me by telephone at \_\_\_\_\_  
 Do  Do Not leave messages on my answering machine.  
 Do  Do Not leave messages with any other person.
- Mail:** I want you to contact me at the following address \_\_\_\_\_
- Email:** I want you to contact me at the following email address \_\_\_\_\_
- Fax:** I want you to contact me by fax at \_\_\_\_\_
- Other:** Other requests for confidential communications (*specify*) \_\_\_\_\_
- Is there anyone involved in your care, or payment of your care with whom we may share your medical information?  
 Yes  No If Yes, person's name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I, \_\_\_\_\_ (print name) have had full opportunity to read and consider the contents of this Consent form and your *Notice of Privacy Practices*. I understand that, by signing this Consent, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*You are entitled to a copy of this consent after you sign it. Include completed Consent in the patient's chart.*

**Acknowledgement of Receipt of Notice of Privacy Practices**

I, \_\_\_\_\_ (print name) have received a copy of this center's *Notice of Privacy Practices*.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_