

Teri Perryman, MD, PA

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Authorization for Treatment Form

The purpose of medical care is to treat disease, injury, and disability by examination, testing, and use of procedures in the aid of diagnosis or treatment; to obtain information needed in diagnosing, and examination of patients; to prevent or minimize residual physical and mental disability; to aid patients in achieving their maximum potential within their capabilities; and to accelerate convalescence and reduce the length of the functional recovery.

You are not expected to experience any increase in your current level of pain or discomfort. You are expected to cooperate fully with the examination and stop any test or treatment before any increase in your current level of pain or discomfort. Because of the nature of services provided you may be asked to disrobe or partially disrobe. If this is necessary, your privacy, modesty, and dignity will be considered at all times by the staff. Should you feel uncomfortable or embarrassed, you may refuse the procedure, stop the procedure and/or request the presence of another person of the same gender.

There are certain inherent risks with medical treatment. There is also a possibility that you could experience a new injury, but this risk is small and you will be able to control any procedure by stopping if you feel any increase in pain or discomfort. You will also be able to stop treatment if you feel any discomfort in any other part of your body. The treating medical practitioner will take every precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure which you do not wish to perform.

Because of the nature of the procedures performed within the clinical setting, your communication with family and friends may be restricted. The clinic reserves the right to restrict visitors and outside communication at any time during your medical treatment sessions to ensure you receive the maximum therapeutic value from treatment. The law requires all staff members to report any evidence of abuse, neglect, and/or exploitation of patients. Should you observe any abuse, neglect, or exploitation by an individual in the clinic you are encouraged to report it immediately. Should you wish to file a complaint or grievance for any reason, you will be provided, in written form, with the names and addresses of appropriate individuals and protective agencies and, if necessary, be given appropriate privacy to complete your communication with those individuals/agencies.

Based on the above information, I agree to cooperate fully and to participate in all medical procedures and to comply with the prescribed treatment plan of care/services as it is established. I acknowledge that I have read the Authorization for Treatment and understand that I may request a personal copy if I wish.

Acknowledgment of Receipt and Consent To Use Protected Health Information

As indicated in our *Notice of Privacy Practices*, disclosures of PHI may be made, without additional patient permission, if they are related to the treatment of the patient, obtaining payment for our services, or office operations, unless the patient has requested such disclosure not be made or be made in an alternative fashion.

- Disclosures made for purposes of treatment, payment or operations will be consistent with the information supplied to our patients in our *Notice of Privacy Practices*. See *Notice of Privacy Practices* policy and procedure. (Copies can be obtained from our office or www.DrPerryman.org/Protected/HIPPAv3a.pdf)
- For purposes of payment or operations, the minimum amount of information necessary to accomplish the intended purpose will be released, but disclosures related to treatment will be made as necessary to assure quality patient care.
- This office may disclose PHI to another covered entity or a health care provider for the payment activities of the entity that receives the information.
- In disclosing PHI for purposes of treatment, payment, and operations, all relevant practices, policies and procedures of Teri Perryman, M.D., P.A. will be followed.
- Pursuant to *Notice of Privacy Practices*, PHI disclosed to any entity may be subject to re-disclosure by the recipient and may no longer be protected by federal HPAA privacy regulations.

I, the undersigned, hereby acknowledge or affirm that:

1. I have received a copy of Teri Perryman, M.D., P.A. Notice of Privacy,
2. I understand that authorization is not necessary for the use and disclosure of Protected Health Information for the purpose of treatment, payment or operations.
3. I understand that any use or disclosure of Protect Health Information outside of treatment, payment and operations will require separate written permission.

This Authorization for Treatment and Acknowledgement of Receipt and Consent to Use Protect Health Information pertains to the following child(ren):

- | | |
|---------|---------|
| 1 _____ | 4 _____ |
| 2 _____ | 5 _____ |
| 3 _____ | 6 _____ |

Parent/Gaurdian

Date