DESERT SPRING
BEHAVIORAL HEALTH

Patient Consent Form

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Desert Spring Behavioral Health** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **Desert Spring Behavioral Health** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Desert Spring Behavioral Health** 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 Lisa Roper, APRN at 640 E. 700 S. Suite 205B, St. George, Utah 84770.

With this consent, **Desert Spring Behavioral Health** may call my home or other alternative location and leave a message on voicemail 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.

With this consent, **Desert Spring Behavioral Health** 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, **Desert Spring Behavioral Health** may email 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 **Desert Spring Behavioral Health** restrict how it uses or discloses my PHI to carry out TPO. 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 allow **Desert Spring Behavioral Health** to use and disclose 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, or later revoke it, **Desert Spring Behavioral Health** may decline to provide treatment to me.

The section below on this page are to be signed at the office.

_____

Signature of Patient or Legal Guardian

_____ _____

Print Patient’s Name Date

_____

Print Name of Legal Guardian, if applicable