Carolina Hand and Sports and Medicine, P.A.
Notice of Patient Health Information and Acknowledgement

Carolina Hand and Sports Medicine, P.A. (CHASM) has a legal responsibility to protect the privacy of your personal health information (PHI). In addition, we are required by law to provide you with our notice.

I have received a copy of Carolina Hand and Sports Medicine, P.A. (CHASM) Notice of Privacy Practices. I am also consenting to the following: CHASM may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. CHASM may mail to my home or other alternative location(s) any items that assist the practice in carrying out treatment or payment operations. CHASM may call my home or other alternative location(s) and leave a message on voice mail regarding reminders, insurance items or pertaining to my treatment. At my request, CHASM may send my personal health information pertaining to treatment, payment or administrative operations using email communication. I understand that this communication method (email) is unencrypted and aware of the potential liabilities. I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations. I retain the right to revoke this consent by notifying the practice in writing at any time. CHASM will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

For Appointment Reminders, I preferred to be contacted by:

☐ **Text messaging #_____** ☐ **Phone call #_____**

☐ **Email: _____**

I give CHASM my consent and authorization to discuss my personal health information to the people and/or facilities I have listed below. This consent and authorization will also include who I have listed as my emergency contact as well.

Name	Relationship	Contact number
Name	Relationship	Contact number
Name	Relationship	Contact number

In case of an emergency, please notify:

Name	Relationship	Contact number

Printed name of Patient:_____

Signature of Patient/Parent/Legal Guardian:_____ Date: _____