Wright State Physicians

Patient Consent Form

Communication Consent

I consent to receiving automated phone calls ____ **Yes** ____ **No**

I consent to receiving text alerts to my mobile phone ____ **Yes** ____ **No**

I authorize Wright State Physicians to discuss my personal health information with the individuals listed below.

Name	**Relationship to Patient**	**Phone Number**
		( )_____
		( )_____

Emergency Contact Only

Name:_____ **Phone:**_____

Name:_____ **Phone:**_____

Patient Portal

To exchange non-urgent messages with your provider and office staff, request appointments, review results, and pay bills. For access to our patient portal, **please list your email address**:_____

Email addresses will not be shared outside of the organization.

Consent to Obtain Medication History

I understand that my medication history may be obtained utilizing an electronic information exchange and that this protected health information may provide valuable information for my healthcare provider. I hereby authorize Wright State Physicians to access my medication history without limitation or exclusion as is required and/or reasonably advisable to disclose, process, retrieve, transmit and view for the purpose of the transmission of an electronic prescription issued by a provider authorized by law to prescribe, as necessary for my care and treatment.

____ Yes, I consent ____ No, I do not consent

Consent for Patient Record Sharing

I authorize Wright State Physicians to securely exchange medical records with other healthcare organizations where I am a patient. I understand that my records will only be exchanged with healthcare organizations where I have been treated.

____ Yes, I consent ____ No, I do not consent

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I received or declined a copy of the Notice of Privacy Practices from Wright State Physicians, which sets forth the ways in which my personal health information may be used or disclosed by Wright State Physicians, and outlines my rights with respect to such information.

Patient Policies

I received and understand Wright State Physicians' Patient Policies.

Education

All health profession students are working under the supervision of a licensed professional. I understand that I may be asked to see a student in this office and that I have the right to decline seeing a student. If you prefer not to have a medical student involved in your visit, please notify the clinical staff.

Research

Researchers may contact me about studies. ____ **Yes** ____ **No**

Researchers may use my health records.* ____ **Yes** ____ **No**

*Research results will not include information that will identify the patient.

Signature of Patient or Guardian_____ **Date:** _____