Hancock
Physician Network

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Hancock Physician Network may use and disclose protected health information (PHI) about me to conduct treatment, payment, and healthcare operation (TPO). Please refer to Hancock Physician Network's Notice of Privacy Practices for a more complete description such uses and disclosures. I have the right to review the Notice of Privacy Practices, which may be obtained upon request.

With my consent, Hancock Physician Network may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in conducting TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results, among others.

With my consent, Hancock Physician Network may mail to my home or designated location any items that assist the practice in conducting TPO, such as appointment reminder cards and patient statements if they designated personal or confidential.

I have the right to request that Hancock Physician Network restrict how it uses or discloses my PHI to conduct TPO. I understand for any services which I paid out-of-pocket in full, the practice will honor my request to not disclose information about those services to my health plan, provided that such disclosure is not necessary to my treatment. In all other circumstances 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 Hancock Physician Network's use and disclosure of my PHI to conduct 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, Hancock Physician Network may decline to provide treatment to me.

GENERAL CONSENT FOR MEDICAL SERVICES

I request and grant permission to Hancock Physician Network, its physicians ("Physicians"), agents, employees, and other members of my care team (collectively "Hancock"), to provide medical care on my behalf as appropriate for my health and well-being.

I acknowledge that neither Hancock nor my Physicians have guaranteed that the services provided on my behalf will have the outcome that I desire. I have not relied on any such guarantees and freely consent to the provision of services.

I acknowledge and understand that the Physicians that treat me at Hancock are licensed to practice medicine under the law of the State of Indiana. By signing below, I provide Hancock my general consent for medical services.

Patient's Name	Date of Birth
Signature of Patient or Legal Guardian	Date
Print Name of Legal Guardian (If not patient)	