

Dennis Dilley MD & Mark Dedmon PA-C
7711 Louis Pasteur #407 San Antonio, Texas 78229
Office: 614-4405 Fax: 614-7892

Patient Consent For The Disclosure of Information

I have read the NOTICE OF PRIVACY PRACTICES and have had the opportunity to ask questions. I understand that this consent applies to me as the patient, or to the patient(s) indicated below for whom I am the parent, guardian, or legal representative.

I understand that by signing this form I consent to the following:

Sharing information for purposes of treatment: You will share information with all members of a treatment team, both within this office and with other providers [personal and institutional] in order to provide with quality care and the educational/wellness programs specified in my insurance plan;

Sharing of Information for Purposes of Payment: You will share all necessary information with insurer[s], payor[s], governmental entities [such as Medicare, Medicaid, etc.] and their representatives [including, but not limited to benefit determination and utilization review] as well as your representatives involved in the billing process [including, but not limited to] claims representatives, data warehouses, billing companies]

Sharing Of Information For Purposes Of Operations: **You will share all information necessary for ingoing operations of this office, including [but not limited to] the credentialing processes, peer review, accreditation and compliance with all federal and state laws.**

Sharing Of Information With Assignment To Others: **You will share information with the following individuals whom I have designated to function in my behalf as needed:**

| First and Last Name | Relationship | Phone Number |
|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|
| | <input type="checkbox"/> Spouse <input type="checkbox"/> Grandparent <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other _____ | |
| | <input type="checkbox"/> Spouse <input type="checkbox"/> Grandparent <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other _____ | |
| | <input type="checkbox"/> Spouse <input type="checkbox"/> Grandparent <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other _____ | |
| | <input type="checkbox"/> Spouse <input type="checkbox"/> Grandparent <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other _____ | |

My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosure given in reliance on this prior consent will be permissible.

Patient's Name [Printed] (Complete if you are the patient) _____
Date

Patient, Guardian, of Legal Representative's Signature _____
Date