5TH VITAL HEALTHCARE
CARE COORDINATION

Consent for Use/Disclosure of Protected Health Information

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain patient rights regarding my protected health information. I, the patient named above or his/her legal representative, authorize 5th Vital Healthcare to use or disclose my protected health information to facilitate my treatment. Such information may be disclosed to insurance companies, healthcare facilities, and physicians or therapists involved in my care. My consent will expire 5 years from the date of this authorization. I have the right to revoke this consent in writing at any time.

Additionally, I give permission to 5th Vital Healthcare and staff to release medical information contained in my file about myself to those indicated below.

Name/Entity: _____

Relationship: _____

NOTICE OF PRIVACY PRACTICES

5th Vital Healthcare has a detailed document called "Notice of Privacy Practices." It provides information on how we may use or disclose your protected health information. Notice of Privacy Practices is located on our website, in the patient portal, and available at your request.

"I understand that I have the right to read this document before signing this agreement."

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____