Atlantic
Prosthetic Services

PATIENT NAME (Please Print) ____

I understand that Atlantic Prosthetic Services (APS), may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment evaluating the quality of services provided and any administrative operations related to my treatment and/or payment. I understand APS will not share any of my information that is not completely necessary for the purpose it was intended. I understand I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I understand I have the right to revoke this consent by notifying APS in writing at any time. I also understand APS will consider requests for restriction on a case by case basis, but does not have to agree to requests for restriction.

I hereby consent to the use and disclosure of my personal health information for the purposes described in this notice.

ATLANTIC PROSTHETIC SERVICES HAS PERMISSION TO:

1. **Leave a detailed message on your voicemail? ☐ YES ☐ NO**
2. **Contact via: ☐ TEXT ☐ EMAIL**
3. **Discuss your medical condition with? (List ALL that apply) ☐ YES ☐ NO**

a) Name ____________________________ Relationship _______________ Ph: ________________

b) Name ____________________________ Relationship _______________ Ph: ________________

c) Name ____________________________ Relationship _______________ Ph: ________________

d) Name ____________________________ Relationship _______________ Ph: ________________

Signed: ____ Date: ________________

Chart # _________

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