

Consent for Services and Insurance HIPAA Acknowledgement

Last Name: _____ First Name: _____ MI: _____ DOB: _____

Consent for Services and Disclosure of Information for Treatment: I consent to evaluation and treatment determined by the nurse practitioners or physicians to be necessary and advisable. I also consent to the use and disclosure of my health information by Lifesprk Health:

- For my treatment, including disclosure to healthcare providers and facilities unrelated to Lifesprk Health that are involved in my care.
- As required reporting data and compliance surveys by state, federal, and accrediting bodies.
- To access my health information from other providers using a record locator service or health information exchange for treatment, unless I object by checking here:

Notice of Privacy Practices and Consent: I acknowledge I have received a copy of Lifesprk Health’s Notice of Privacy Practices and I understand that I have a right to review these privacy practices before signing this consent form. I understand that Lifesprk Health may change its privacy practices in the future, and that I may request a copy of the new privacy practices at any time. I also understand that I can contact Lifesprk Health’s Privacy Officer with any questions I may have about the Notice of Privacy Practices. In addition to the other uses and disclosures described in this document, I consent to the use and disclosure of my health information for the purposes described in the Notice of Privacy Practices, including Lifesprk Health’s health care operations.

Insurance Assignment and Payment Consent: I authorize payments directly to Lifesprk Health or Medicare benefits, or funds from other sources I am entitled to receive as payment for services provided to me. I consent to the use and disclosure of my health information for payment purposes. My insurer may share my past, current, and future health and account records with Lifesprk Health about services received from Lifesprk Health and care providers unrelated to Lifesprk Health. These records may be used by Lifesprk Health as needed to manage, coordinate, and to improve the quality of my care.

If I do not agree, I will check the box below.

My insurer may not release health information from providers unrelated to Lifesprk Health for the purposes described above.

Use of Health Care Records in Program Evaluations and Trainings: I give Lifesprk Health permission to use and disclose information gathered during the course of my treatment from Lifesprk Health, including information from my treatment records, for the purposes of program evaluation and training, and for quality review of the staff performance at Lifesprk Health.

Chronic Care Management: I give Lifesprk Health permission to enroll me in Lifesprk Health which includes appropriate nurse practitioner or physician care/management visits and activities, which will be billed to my insurance with normal deductibles and copays. I understand information on these programs is included in the enrollment information and on the web site.

Consent for Use of Medical Records in Academic Research: I authorize Lifesprk Health to use or disclose my health records for medical or academic research, including health records created at any time by Lifesprk Health and records Lifesprk Health received from other health care providers, unless I object by checking here: At my request, Lifesprk Health will tell me the dates on which my health records are released for research and tell me how to contact external researchers who have received my records.

This consent applies to health information that Lifesprk Health already has about me, information about future care I may receive from Lifesprk Health, and information Lifesprk Health receives from third parties. This consent will continue unless I cancel by giving written notice to Lifesprk Health or it expires as required by law. Cancellation will apply only after the date when the notice to cancel is received. It will not affect information that was used or disclosed before the cancellation.

Member signature (or legal rep)	Printed name	Date
Email	<input type="checkbox"/> No email address	
Name of legal representative	Relationship to member	