R & R Psychiatric Care

2680 S Val Vista Dr, Building 15 Suite 185, Gilbert, AZ 85295
Office (480) 630-4434 Fax (480) 630-5285 www.rrwellness.org

Consent for Use and Disclosure of Protected Health Information

Today's Date: ____________ Client Name: ________________________________ Date of Birth: _____________

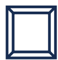
Address: ____ City, State, Zip: ______________________________

Preferred Phone Number: _____________________ Preferred Email: __________________________________

I hereby give my consent for R & R Psychiatric Care and its staff ("Clinic") to use and disclose my protected health information (PHI) to perform treatment, payment, and healthcare operations ("TPO").
(The Notice of Privacy Practices provided by Clinic describes such uses and disclosures more completely.)
I have the right to review the HIPAA Notice of Privacy Practices prior to signing this consent. R & R Psychiatric Care reserves the right to revise its HIPAA Notice of Privacy Practices at any time; the current notice can be viewed at any time on the Clinic website www.rrwellness.org/faq

By signing this form, I am consenting to allow R & R Psychiatric Care and its staff to use and disclose my PHI to carry out TPO. I give my consent to be contacted for appointment reminders, insurance items, payment information, and anything pertaining to my clinical care, such as laboratory test results or prescription information. Contact methods include voice, SMS text messaging, email, and postal mail.

SMS Terms of Service



By opting into SMS from a web form or other medium, I am agreeing to receive SMS messages from R & R Psychiatric Care. This includes SMS messages for appointment scheduling, appointment reminders, post-visit instructions, lab notifications, and billing notifications. Message frequency varies. Message and data rates may apply. See privacy policy at https://www.rrwellness.org/privacypolicy. Message HELP for help. Reply STOP to any message to opt out.

Okay to discuss my health or billing information with:

NAME: ____ Relationship: _____________________________

NAME: ____ Relationship: _____________________________

ACKNOWLEDGEMENTS

1. I have received a copy of this consent, have read and understand the information, and I consent for R & R Psychiatric Care to use and disclose my PHI for these purposes.
2. This consent does not expire. I may revoke my consent in writing except to the extent that R & R Psychiatric Care has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, R & R Psychiatric Care may decline to provide treatment to me.
3. I agree that a photocopy or electronic copy of this consent shall be considered as valid as the original.
4. If applicable, I attest that I am the legal guardian and have the right to consent on behalf of this minor.

____ ________________________________ __________________

Signature of Client or Legal Guardian | Printed Name | Date

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Name of Client if a Minor