PSYCHIATRY ASSOCIATES

P A K C

OF KANSAS CITY

Psychiatry Associates of Kansas City (PAKC) has adopted a policy to be compliant with HIPAA Privacy Regulation, requiring physicians and staff to obtain authorization from the patient to leave detailed messages for that patient. If there is not a signed consent on file, PAKC will only leave a name and telephone number on an answering machine, voicemail or with a person answering the phone.

PAKC may use and disclose protected health information about me to carry out payment processes, treatment continuity and healthcare operations without my consent.

I have the right to review the Notice of Privacy Practices prior to signing this consent. PAKC reserves the right to revise its Notice of Privacy Practices at anytime without prior notifications. Notices of Privacy Practices may be obtained at the front reception desk at 8900 State Line Road, Suite 380, Leawood Ks 66206 or by forwarding a written request to the above address.

By completing the information below, you will be consenting to allow PAKC's physicians and staff to leave a detailed message on an answering machine, voicemail, or with a specific individual. Check all that apply.

Type of information is in bold.

SCHEDULING/APPTS	**TREATMENT/LAB INFO**	**BUSINESS OFFICE**
_____ on answering machine at home	_____ on answering machine at home	_____ on answering machine at home
_____ on answering machine at cell phone	_____ on answering machine at cell phone	_____ on answering machine at cell phone
_____ on answering machine/voicemail at work	_____ on answering machine/voicemail at work	_____ on answering machine/voicemail at work
With specific individual _____	With specific individual _____	With specific individual _____
With specific individual _____	With specific individual _____	With specific individual _____

_____ I DO NOT CONSENT TO MESSAGES BEING LEFT AT HOME, WORK OR WITH ANYOTHER PERSON. I WISH TO BE CONTACTED DIRECTLY.

I may revoke my consent in writing except to the extent that the practice has already made disclosures. If I do not sign this consent, PAKC may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Print Patient's Name Date

Print Name of Legal Guardian Relationship to patient