

**GREATER CHESAPEAKE HAND SPECIALISTS, P.A.**  
**PATIENT CONSENT**  
**USES AND DISCLOSES REQUIRING AN OPPORTUNITY FOR THE INDIVIDUAL**  
**TO AGREE OR OBJECT**

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

By signing this form, I consent to GCHS' use and disclosure of my Protected Health Information for the purposes of *treatment, payment and/or health care operations* as defined in the Privacy Notice of GCHS.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Witness

**I acknowledge receipt of the Notice of Privacy Practices.** \_\_\_\_\_  
*Patient's Initials*

**CONTACT INFORMATION**

**1) HOW SHOULD WE CONTACT YOU?**

You have the right to request us to contact you in a certain way or at a certain place. Please let us know if you have a contact preference, e.g. cell phone, home, work:

\_\_\_\_\_  
\_\_\_\_\_

**2) TO WHOM MAY WE DISCLOSE (Person to whom GCHS or LSC MAY USE OR DISCLOSE PHI\*)**

Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_

Home Tel: \_\_\_\_\_

Work Tel: \_\_\_\_\_

Other contact information, e.g. cell phone \_\_\_\_\_

**3) TO WHOM MAY WE NOT DISCLOSE (Person to whom GCHS or LSC MAY NOT USE OR DISCLOSE PHI\*)**

Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_