RE • GEN
ATHLETIC MEDICINE

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: CLIENT CONTACT INFORMATION

Name:_____

Address:_____

Telephone:_____ E-mail:_____

SECTION B: TO THE CLIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to ReGen Athletic Medicine ("ReGen") use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations (the "Consent") by ReGen.

Notice of Privacy Practices: You have the right to read ReGen's Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice of Privacy Practices provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

ReGen may leave voicemails and send text messages, email or mail to the contact information provided above regarding my appointments, treatment or other protected health information related to my care with ReGen _____ [*initial*]

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed below. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

ReGen Athletic Medicine
Katie Donnelley, MS, ATC
4207 SE Woodstock Blvd., #500, Portland, OR 97206

PRINT & SIGNATURE

I,_____, have had full opportunity to read and consider the contents of this Consent and ReGen's Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to ReGen's use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature:_____ Date:_____

If this Consent is signed by a personal representative, parent or guardian on behalf of the patient, complete the following:

Personal Representative/Parent/Guardian Name:_____

Relationship to Patient:_____

Signature:_____