

Gael Wheeler, D.O.
Doctorgael@gmail.com

HIPAA

With my consent, Gael Wheeler, D.O. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Gael Wheeler, D.O. Care's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Gael Wheeler, D.O. reserves the right to revise its Notice of Privacy Practice at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Gael Wheeler, D.O. at doctorgael@gmail.com

With my consent, Gael Wheeler, D.O. may call my home or other designated location and leave a message on my voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items or any call pertaining to my clinical care, including laboratory results among others.

With my consent, Gael Wheeler, D.O. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Gael Wheeler, D.O. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Gael Wheeler, D.O use and disclosure of my PHI to carry out TPO.

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

Signature of Patient or Legal Guardian

Patient's Name

Date

Print Name of Patient of Legal Guardian