



PATIENT CONSENT

CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that Tactile Medical (Tactile) originates, collects and maintains paper and/or electronic records describing my Protected Health Information (PHI) such as health history, diagnosis, symptoms, test results, etc. I consent to the use and disclosure of my PHI by Tactile, its staff, and its business associates for treatment, payment and health care operations.

I understand I have a right to request restrictions or revoke any use and/or disclosure of my PHI by Tactile. A detailed description of my rights was provided to me in the Notice of Privacy Practices. This authorization is effective for 5 years unless otherwise provided by law.

I consent to the release of PHI by Tactile to my health care providers and insurance company(ies). I authorize and consent to the release by my health care providers to Tactile and any insurance company(ies), all PHI necessary to secure payment.

I understand Tactile may desire to review de-identified health information for the purposes of clinical research, evaluation of patient outcomes, or clinical protocol development. I consent to the release and use of my de-identified information so long as Tactile ensures that I cannot be identified through release and use of that information.

ASSIGNMENT OF BENEFITS

I assign payment of medical benefits to Tactile and direct any payer to make payment on my behalf directly to Tactile. I understand that all costs not covered by my insurance are my responsibility. I understand that in the event my insurance company makes payment directly to me for the medical equipment provided by Tactile, I am responsible for ensuring payment in full is made promptly to Tactile.

CONSENT TO LEAVE MESSAGES

I authorize Tactile to leave voice mail messages for me regarding medical and/or billing information at the following number(s):

(_____) _____ Day Evening (_____) _____ Day Evening

I authorize Tactile to leave messages with or respond to inquiries from the following individual(s):

NAME RELATIONSHIP PHONE

NAME RELATIONSHIP PHONE

I do not authorize Tactile to leave voice mail messages containing medical or billing information.

CONSENT TO EMAIL

I grant permission to use the email address provided for the sole purpose of communicating with me regarding my Tactile order. I understand that in order to secure my electronic PHI, email messages from Tactile may be encrypted. Encrypted email will require that I click on a provided link and create a password in order to view the secure email.

EMAIL ADDRESS

PATIENT SIGNATURE

By signing this, I agree to all the terms and conditions listed above.

PATIENT NAME (PLEASE PRINT) PATIENT SIGNATURE DATE

GUARDIAN NAME (IF APPLICABLE, PLEASE PRINT) GUARDIAN SIGNATURE DATE

Please return completed form to Tactile Medical. **Mail:** 1331 Tyler Street NE, Suite 200, Minneapolis, MN 55413 **Fax:** 866.435.3949
To speak with a Patient Services representative, call toll-free: 866.435.3948

Tactile Medical

1331 Tyler Street NE, Suite 200 Toll-Free Tel: 866.435.3948 Hours: Monday through Friday, 8 a.m. – 5 p.m. CT
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