

# Sparks Family Medicine

653 Town Center Drive, Suite 514

Las Vegas, Nevada 89144

(702) 243-2689 Phone

(702) 243-2632 Fax

---

## Treatment Results Consent Form

To comply with state and federal law concerning the disclosure of protected health information (PHI), Sparks Family Medicine, Inc. requires that you indicate how treatment results should be communicated to you or your personal representative. Please choose one of the following:

- PLEASE CALL MY LAB RESULTS TO ME. I would like for treatment results to be phoned to the following number provided by me. I understand that the information disclosed will be minimal, such as first name, the name of our office, results of either “normal” or “abnormal,” basic treatment result data, (e.g., cholesterol levels) and our office telephone number.

Phone Number: \_\_\_\_\_

- PLEASE **DO NOT** CALL MY LAB RESULTS TO ME. I will make follow-up appointments to receive treatment results in person. I understand that this appointment will be treated as any other appointment, with payment, i.e. co-payment, deductible, patient responsibility, due at time of service.

Your rights as outlined in the Notice of Privacy Practices provided to you by this office are still protected, regardless of how you chose for results to be communicated to you or your personal representative. This consent form will remain in effect unless changed, in writing, by you or your personal representative.

*Please note that any **analysis** of treatment results **will** require an appointment.*

I \_\_\_\_\_ hereby indicate on this form my preference for  
**Print** Name of Patient or Personal Representative

disclosing treatment results on this date of \_\_\_\_\_.  
Month/Day/Year

Signature of Patient or Personal Representative: \_\_\_\_\_  
**Sign Here**