PATIENT CONSENT FORM

For Use and Disclosure of Protected Health Information

I hereby give my consent for Family Medicine Associates to use and disclose protected health information (PHI) about me to carry out treatment, payment and health operations (TPO). (The notice of Privacy Practices provided by Family Medicine Associates describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Family Medicine Associates reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Family Medicine Associates.

With this consent, Family Medicine Associates may call my home or other alternative locations and leave a message on my voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results among others.

With this consent, Family Medicine Associates may mail to my home or other alternative location any items that assist in the practice in carrying out TPO, such as appointment card reminders and patient statements as long as they are marked "Personal and Confidential" .

By signing this form, I am consenting to allow Family Medicine Associates to use and disclose 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, or later revoke it, Family Medicine Associates may decline to provide treatment to me.

SIGNED BY: ____ DATE: ____________________

Signature of Patient or Legal Guardian

____ ____

Print Patient's Name | Patient's Date of Birth

____ ____

Print Name of Legal Guardian, if applicable | Relationship to Patient