SOUTH FORSYTH FAMILY MEDICINE AND PEDIATRICS

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give consent for **South Forsyth Family Medicine & Pediatrics (SFFMP)** to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). (The Notice of Privacy Practices provided by SFFMP describes such uses and disclosures more completely.

With this consent, SFFMP may call my home or other alternative location and leave a message on voice mail, answering machine, or with a person in reference to any items that assist the practice in carrying out TPO. Such items include appointment reminders, insurance items, and any calls pertaining to my clinical care. SFFMP maybe mail to my home or other alterative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, test results and patient statements. With this consent, SFFMP may also email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, test results and patient statements.

I have been offered a written copy of the **Notice of Privacy Practices** of SFFMP prior to signing this consent. SFFMP reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices will be posted in the office or may be obtained by forwarding a written request to the Privacy Officer, SFFMP, 1845 Lockeway Drive STE 404, Alpharetta, GA 30004.

I have the right to request, in writing, that SFFMP restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

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, SFFMP may decline to provide treatment to me.

I also give my consent for SFFMP to disclose my health information to the following person(s): _____

_____

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

If not patient, name of legal guardian: _____

Relationship: _____

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Internal Use Only:

If patient or patient's representative refuses to sign the Patient consent for Use and Disclosure of Protected Health Information, please document date and time the notice was presented to patient and sign below.

Presented on (date & time): _____ by (name & title): _____