PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, East Belt Family Medicine PA may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to East Belt Family Medicine'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. East Belt Family Medicine reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Susana Garcia Privacy Officer at 5402 E. Sam Houston Pkwy. N. Houston, Tx. 77015.

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

With my consent, East Belt Family Medicine 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 as long as they are marked Personal and Confidential.

Upon patient request (verbal and/or written), East Belt Family Medicine can mail lab results to address on file.

By signing this form, I am consenting to East Belt Family Medicine's 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, East Belt Family Medicine may decline to provide treatment to me.

I give Dr. Garcia and/or his staff permission to obtain my prescriptions received from other doctors and/or facilities.

____
Signature of Patient or Legal Guardian

____________________________________ ____________________
Patient's Name Date

____
Print Name of Patient or Legal Guardian

Please list anyone who you would like to have access to your medical information. This information may include your diagnosis, prognosis, test results, appointment and/or billing information. You do not need to list your referring physician, but you do need to list family members, friends, caretakers, and/or employers. If you do not want your information to be released to anyone, please leave blank.

Name: ________________ Relation: ________________ Phone: __________

Name: ________________ Relation: ________________ Phone: __________

Name: ________________ Relation: ________________ Phone: __________