Jupiter Family Medicine, P.C.

Patient Consent for Use and Disclosure Of Protected Health Information

Patient Name: _____ Date of Birth: _____

I hereby give my consent for Jupiter Family Medicine 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 Jupiter Family Medicine describes such uses and disclosures more completely).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Jupiter Family Medicine 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 our office.

_____ Please initial to acknowledge that you have reviewed Jupiter Family Medicine's Notice of Privacy Practices.

I request that all communications to me (by telephone, mail, etc.) by Jupiter Family Medicine and/or its staff be handled in the following manner:

- For **written** communications: Address to: _____
  _____
  _____

- For **oral** communications: Call: _____
  (telephone number)

  May we leave a detailed message? ☐ YES ☐ NO

In the event that I am unavailable, I give Jupiter Family Medicine authority to share PHI with the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

With this consent, Jupiter Family Medicine may call the number above and leave a message on voice mail or with a listed individual 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, Jupiter Family Medicine may mail to the address above any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and items pertaining to my clinical care, including laboratory test results, among others. I have the right to request that Jupiter Family Medicine restrict how it uses or discloses by 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.

If the above address is not your home address or primary mailing address, please provide us with an alternate address for purposes of ensuring payment:

_____

_____

In the event that a document containing PHI, such as medical records, a completed form, or a prescription, will be picked up at the office of Jupiter Family Medicine, I give Jupiter Family Medicine the authority to release the items to the following individuals (a photo ID will be required):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

By signing this form, I am consenting to allow Jupiter Family Medicine 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, Jupiter Family Medicine may decline to provide treatment to me.

_____ _____

Patient/Patient Representative Signature Date

_____

Relationship to Patient (if other than patient)

For Practice Use Only:

Practice: □ Accepts □ Denies

_____ _____

Privacy Officer Signature Date