

HINDS MEDICAL GROUP

PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Hinds Medical Group to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations. (The Notice of Privacy Practices provided by Hinds Medical Group describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Hinds Medical Group 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 Hinds Medical Group.

With this consent, Hinds Medical Group may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Hinds Medical Group may mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements."

With this consent, Hinds Medical Group may e-mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements. I have the right to request that Hinds Medical Group restrict how it uses or discloses my PHI to carry out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Hinds Medical Group to use and disclose my PHI to carry out treatment, payment, and health care operations.

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, [insert name of practice] may decline to provide treatment to me.

Signed by: _____
Signature of Patient or Legal Guardian Date Relationship to Patient

Print Patient's Name Print Name of Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.