Patient Consent for use and Disclosure of Protected Health Information

I hereby give my consent for **Acute Family Medicine Clinic, Inc.** 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 **Acute Family Medicine Clinic, Inc.** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Acute Family Medicine Clinic, Inc.** 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:

Daniel Coverdell, MD
Acute Family Medicine Clinic, Inc.
11470 Business Blvd., Suite 100
Eagle River, AK 99577.

With this consent, **Acute Family Medicine Clinic, Inc.** may call my home or other alternative location and leave a message on voice mail (unless a refusal to Allow Voice Mail Form is completed 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, **Acute Family Medicine Clinic, Inc**. may mail to my home or other alternative location any items that 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."

With this consent, **Acute Family Medicine, Inc.** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Acute Family Medicine Clinic, Inc.** 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.

By signing this form, I am consenting to allow **Acute Family Medicine Clinic, Inc.** 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, **Acute Family Medicine Clinic, Inc.** may decline to provide treatment to me.

_____ _____

Print Patient's Name **Signature of patient or Legal Guardian**

_____ _____

Date **Print Name of legal Guardian, if applicable**