Atlantic Adult & Pediatric Medicine

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Atlantic Adult & Pediatric 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 Atlantic Adult & Pediatric Medicine describes such uses and disclosures more completely).

With this consent, Atlantic Adult & Pediatric Medicine 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. Atlantic Adult & Pediatric Medicine may mail 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. With this consent, Atlantic Adult & Pediatric Medicine may also e-mail 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 Atlantic Adult & Pediatric Medicine prior to signing this consent. Atlantic Adult & Pediatric Medicine 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 Office, Atlantic Adult & Pediatric Medicine, 34435 King Street Row, Suite 1, Lewes, DE 19958.

I have the right to request, in writing, that Atlantic & Pediatric Medicine 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, Atlantic Adult & Pediatric Medicine may decline to provide treatment to me.

_____ (Initial) I was offered and <u>received / declined</u> a copy of the Notice of Privacy Practices.

I also give my consent to AAPM to disclose my health information to the following:

NAME: _____ Relationship: _____ Phone Number: _____

NAME: _____ Relationship: _____ Phone Number: _____

NAME: _____ Relationship: _____ Phone Number: _____

NAME: _____ Relationship: _____ Phone Number: _____

Patient Name: _____

Signature: _____ Date: _____

In not patient, name of legal guardian: _____ Relationship: _____

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 and time): _____ By (name & title): _____