Montgomery Internal Medicine Group/Atlantic Medical Group

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Montgomery Internal Medicine Group, PC, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).
I understand that Montgomery Internal Medicine Group may release my PHI to a family member, friend, or other person I indicate is involved in my care unless I object. I designate the following person(s) listed below as a person or persons involved with my health care and/or payment for my health care (circle as applicable), to whom the information circled "yes" below may be released:

Name:______________________________ Relationship:____________________________

Address/Phone:____

Health Info: YES / NO [circle as applicable] Payment Info: YES / NO [circle as applicable]

Name:______________________________ Relationship:____________________________

Address/Phone:____

Health Info: YES / NO [circle as applicable] Payment Info: YES / NO [circle as applicable]

Name:______________________________ Relationship:____________________________

Address/Phone:____

Health Info: YES / NO [circle as applicable] Payment Info: YES / NO [circle as applicable]

I wish to be contacted in the following manner (mark all that applies):

Home telephone__________________
Detailed Message YES NO
Call Back Message Only YES NO

Cell phone__________________
Detailed Message YES NO
Call Back Message Only YES NO

Work phone____________________
Detailed Message YES NO
Call Back Message Only YES NO

Mail to Home Address [ ] Mail to Work Address [ ]

Mailing Address: ____

By signing this form, I am consenting to Montgomery Internal Medicine Group's, PC use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Montgomery Internal Medicine Group, PC may decline to provide treatment to me.

____________________________ ____________________ ____________________
Print Name of Patient/Legal Guardian Effective Date of Consent Expiration of Consent

____
Signature of Patient/Legal Guardian