Whitesburg Family Medicine

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Receipt of Privacy Practices; Consent for Use / Disclosure of Protected Health Information (PHI)

I, ____, was provided a copy of Whitesburg Family Medicine's Privacy Practices Notification. Whitesburg Family Medicine may revise it's notification at any time. I understand that a copy is always available at my request. By signing this document I acknowledge that I have read, understand and agree to the terms of this consent. Further, I hereby consent and authorize Whitesburg Family Medicine to use or disclose my PHI in conjunction with Whitesburg Family Medicine's treatment, payment or healthcare operations in accordance with the terms of this consent.

____ ____________________________________

Signature of Patient / Guardian **Date**

Further I hereby authorize and give my consent to Whitesburg Family Medicine to leave messages on my answering machine / voicemail for the following (check all that apply)

Appointment Reminders _______ **Prescription Refills** ______

Medical Information _______ **Test Results** ______

Insurance / Payment Issues _______ **Mail** ______

I further authorize and give consent to Whitesburg Family Medicine to communicate any of my PHI to the following person / persons:

Name	Relationship

____ ____________________________________

Signature of Patient / Guardian **Date**