Piedmont Family Practice
Your Medical Home

Authorization to Use and Disclose Protected Health Information
Piedmont Family Practice

Use and Disclosure of Your Protected Health Information:
Your protected health information will be used by or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operation of the practice. There is potential for re-disclosure. The person or organization to which health information is sent my repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

Notice of Privacy Protection:
We are required to provide you with a notice that describes how information about you may be disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the "Notice of Privacy Policies and Practices" letter provided to you. PLEASE REVIEW CAREFULLY.

Requesting a Restriction on the Use or Disclosure of Your Information:
You may request a restriction on the use or disclosure of your protected health information. Piedmont Family Practice may or may not agree to restrict the use of disclosure of your protected health information. If Piedmont Family Practice agrees to your request, the restriction will be binding on the practice. Use of disclosure of protected health information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent:
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which you revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices:
Piedmont Family Practice reserves the right to modify the privacy outlined in the notice. I understand the Piedmont Family will notify me of these changes via the method I have authorized or upon my next appointment.

1. Please list family members or other persons, if any, whom we may inform about you general medical condition and your diagnosis. If you wish a spouse, step-parent, child, secretary, friend, etc. to have access to appointment times, health information, and/or billing information, please list them here:

PLEASE CIRCLE ONE OF THE FOLLOWING BELOW:

_____ May have access to: all info Billing info only diagnosis/medical info only

_____ May have access to: all info Billing info only diagnosis/medical info only

_____ May have access to: all info Billing info only diagnosis/medical info only

_____ May have access to: all info Billing info only diagnosis/medical info only

_____ May have access to: all info Billing info only diagnosis/medical info only

2. Your billing statement and/or correspondents from our office will be sent to the address provided by you on your patient information sheet. All clinical correspondence will be marked "**CONFIDENTIAL**" when mailed directly from our office.
3. The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are done by telephone and a brief, nonspecific message may be left on your machine or voicemail. The home number you provided when registering will be used to contact you. We may also leave messages regarding treatment and/or other information pertinent to your healthcare and payment for your care provided at Piedmont Family Practice.

I have reviewed this consent form, received the notice entitled "Notice of Privacy Policies and Practices" and give my permission to Piedmont Family Practice to use and disclose my health information in accordance with this consent and the notice provided.

_____ _____ _____
Name of Patient (please print) (Signature of patient of patient representative) Date

_____ _____
Patient Birthday Relationship of Patient Representative to Patient