PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Southside Medical Care to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Southside Medical Care's Notice of Privacy Practices provides a more complete description of such uses and disclosure's.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Southside Medical Care 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 6325 Shannon Parkway, Union City, GA 30291.

With this consent, Southside Medical Care may call my home or alternative location and leave a voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Southside Medical Care may email me and/or send mail to my home or 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 Southside Medical Care restrict how it uses or disclosures my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Southside Medical Care's use that disclosure of 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, Southside Medical Care may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Print Name of Patient or Legal Guardian

I wish to be contacted in the following manner (check all that apply)

___ **Home Phone** _____-_____-_____

___ Permission to leave message with detailed information

___ Permission to leave message with call-back number only

___ **Cell Phone** _____-_____-_____

___ Permission to leave message with detailed information

___ Permission to leave message with call-back number only

___ **Written Communication**

___ Permission to mail to my home

___ **Other** _____

_____

Signature of Patient or Legal Guardian

Date

Print Name of Patient or Legal Guardian

Date of Birth