Patient Consent Form

Patient Consent for Use/Disclosure of Health Care Information

Patient's Name: _____ Date of Birth: _____

Previous Name: _____

I understand that the patient's health information is private and confidential. I understand that Toccoa Clinic Medical Associates, LLP (hereinafter referred to as "TCMA") works very hard to protect the patient's personal health information.

I understand that TCMA may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations.

TCMA has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this agreement.

TCMA may update this "Notice of Privacy Practices". If I ask, TCMA will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I can ask TCMA to limit how the patient's personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that TCMA does not have to agree to my request. If TCMA does agree to my request, I understand that TCMA would follow the agreed limits.

I give permission to TCMA to contact me by e-mail, phone and leave phone messages on my answering machine or voice mail. These phone calls and/or messages may be in regard to my appointments, status of health or financial standing, but are not limited to these topics.

I may cancel this consent in writing at any time by doing one of the following:

1. Signing and dating a form that TCMA can give me called "Revocation of Consent for Use and Disclosure of Health Care Information", or
2. Writing, signing, and dating a letter to TCMA. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment, and health care operations.

If I revoke this consent, TCMA does not have to provide any further health care services to the patient.

My signature below indicates that I have been given the chance to review a current copy of TCMA's "Notice of Privacy Practices". My signature means that I agree to allow TCMA to use and disclose the patient's personal health information to carry out treatment, payment, and health care operations.

Patient or legally authorized individual signature **Date** **Time**

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)