

MID-ATLANTIC PULMONARY CLINIC
MARIA L. JISON, MD, LLC

PATIENT CONSENT FOR USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION

I hereby give my consent for Mid-Atlantic Pulmonary Clinic (PRACTICE) to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations. (The Notice of Privacy Practices provided by PRACTICE describes such uses and disclosures more completely and is continually posted on the wall in the waiting room at PRACTICE.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. PRACTICE reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Tomi Ridgway at PRACTICE.

With this consent, PRACTICE may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, PRACTICE may mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements."

With this consent, PRACTICE may E-MAIL to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements. I have the right to request that PRACTICE restrict how it uses or discloses my PHI to carry out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow PRACTICE to use and disclose my PHI to carry out treatment, payment, and health care operations.

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, [insert name of practice] may decline to provide treatment to me.

Signed by: _____
Signature of Patient or Legal Guardian Date Relationship to Patient

Print Patient's Name Print Name of Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.