ROSE AVENUE FAMILY MEDICAL GROUP

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Rose Avenue Family Medical Group to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (The Notice of Privacy Practices provided by Rose Avenue Family Medical Group describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Rose Avenue Family Medical Group 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 the Office Manager of Rose Avenue Family Medical Group.

With this consent, Rose Avenue Family Medical Group 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 TPO, such as appointment reminders, insurance items and any calls pertaining to clinical care, including laboratory results, among others.

With this consent, Rose Avenue Family Medical Group may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

With this consent, Rose Avenue Family Medical Group may e-mail to my home or other 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 Rose Avenue Family Medical Group restrict how it uses or discloses my PHI to carry out TPO. 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 Rose Avenue Family Medical Group to use 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, Rose Avenue Family Medical Group may decline to provide treatment to me.

Date: ____

Signed by: ____

Signature of Patient or Legal Guardian

_________________________________ _________________________

Print Patient Name Relationship to Patient