Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Infectious Diseases Associates, P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Infectious Diseases Associates, P.C. Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Infectious Diseases Associates, P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy may be obtainedby forwarding a copy to Infectious Diseases Associates, P.C. Privacy Officer at 6285 Garden Walk Blvd, Suite A Riverdale, GA 30274.

With this consent, Infectious Diseases Associates, P.C. may call my preferred contact number as provided by the patient and leave a message on the 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 my clinical care. I also understand that it is my responsibility to notify the practice of changes related to my address, phone number, email address, insurance information or any other personal information required to contact or bill me.

With this consent Infectious Diseases Associates, P.C. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment change notifications and patient statements. I have the right to request that Infectious Diseases Associates, P.C. restrict how it uses my PHI to carry out TPO. However, the practice is not required to agree to my personal requests, but if it does, it is bound by this agreement. With this consent, I understand that if I call to obtain lab results, or test results, I will be asked for my date of birth. In addition, I understand that I will be asked my date of birth before scheduling an appointment. These confirmations will serve to protect the identity of the patient. With this consent, I also authorize the following person(s) if any to inquire or be notified of my PHI should I be unable to inquire for myself. They will also be required to know my date of birth.

Name of alternate person(s) to release private health information to:

1:__________________ 2:____________________

By signing this form, I am consenting to Infectious Diseases Associates, P.C. use and 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. I have also read the Office Policy and the Notice of Privacy Practices has been made available to me.

________________________________ ___________
Signature of Patient or Legal Guardian Date

____________________________________ _________
Printed Name of Patient or Legal Guardian Date