Family Healthcare of Lake Norman, PC

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Family Healthcare of Lake Norman** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by **Family Healthcare of Lake Norman** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Family Healthcare of Lake Norman** 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: **Vince Winegardner, 9718-A Sam Furr Rd, Huntersville, NC 28078.**

With this consent, **Family Healthcare of Lake Norman** 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 my clinical care, including laboratory test results, among others.

With this consent, **Family Healthcare of Lake Norman** 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.

With this consent, **Family Healthcare of Lake Norman** may communicate my health condition to the following persons (Name/Relationship):

_____

With this consent, **Family Healthcare of Lake Norman** 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 **Family Healthcare of Lake Norman** 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 **Family Healthcare of Lake Norman** to use and disclose my PHI to carry out TPO. I also agree that my PHI may be shared with designated third party's (Insurance companies) which I have contracted to pay for my medical services.

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, **Family Healthcare of Lake Norman** may decline to provide treatment to me.

In the event of an emergency, please contact the following person:

Name _____ Telephone No. _____

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable