



Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for the office of Saint Joseph's Medical Group to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). [The office's 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. The office of Saint Joseph's Medical Group reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Administrator.

With this consent, the office of Saint Joseph's 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 may assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the office of Saint Joseph's Medical Group may mail to my home or their 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, the office of Saint Joseph's Medical Group may e-mail to my home or other alternative location any time that assists the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the office of Saint Joseph's Medical Group restrict how it uses or discloses my PHI to carry out TPO. However, 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 the office of Saint Joseph's Medical Group 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. If I do not sign this consent, or later revoke it, the office of Saint Joseph's Medical Group may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Name

Print Name of Patient or Legal Guardian

Date