

# Texas Family Medicine

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## Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Texas Family Medicine 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 Texas Family Medicine describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Texas Family Medicine 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 Brandi Cook, Practice Administrator, 8380 Warren Pkwy, Suite 100, Frisco, TX 75034.

With this consent, Texas Family Medicine 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, Texas Family Medicine 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, Texas Family Medicine 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 Texas Family Medicine 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 Texas Family Medicine to use and disclose 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, Texas Family Medicine may decline to provide treatment to me.

Signed by: \_\_\_\_\_  
Signature of Patient or Legal Guardian      Relationship to Patient

\_\_\_\_\_  
Print Patient's Name      Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian, if applicable