

Premiere Health and Wellness

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Premiere Health and Wellness may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Premiere Health and Wellness Notice of Privacy Practices for 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.

Premiere Health and Wellness 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 Privacy Officer, Premiere Health and Wellness, 1710 1/2 Alice Street, Waycross, Georgia 31501.

With my consent, Premiere Health and Wellness may call my home or other designated 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 call pertaining to my clinical care, including laboratory results among others.

With my consent, Premiere Health and Wellness may mail to my home or other designated 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 my consent, Premiere Health and Wellness may email to my home or other designated 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 Premiere Health and Wellness 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 Premiere Health and Wellness 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, Premiere Health and Wellness may decline to provide treatment to me.

Patient's Name

Date of Birth

If Minor Print Name Legal Guardian

Signature of Patient or Legal Guardian

Date

Premiere Health and Wellness may discuss my medical condition/information with the following:

Name of Person: _____ Relationship: _____

Phone Number: _____

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Phone Number: _____