

Patient consent for use and Disclosure of Protected Health Insurance

I hereby give my consent for American Professional Associates (APA) to use and disclose protected health insurance information (PHI) about me to carry out treatment and healthcare operation (TPO). (APA'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. American Professional Associates 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 American Professional Associates, Privacy Officer at: 7820 Roswell Road, Atlanta, GA 30350.

With this consent, APA may mail to my home or other alternative locations and leave a message on voicemail 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 results, among others.

With this consent, APA may mail to my home or alternative locations 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 APA 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 the agreement.

By signing this form, I am consenting to APA's 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, APA may decline treatment to me.

Signature or Patient or Legal Guardian

Date

Patient Name

Print name of legal guardian (if applicable)