Atlanta Oncology
ASSOCIATES, P.C.

Consent for use and disclosure of Protected Health Information

I hereby give my consent to Atlanta Oncology Associates, and its affiliates (AOA) to use and disclose protected health insurance information (PHI) about me to carry out treatment, payment and healthcare operation (TPO). (AOA 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. Atlanta Oncology Associates, and its affiliates (AOA) 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 Atlanta Oncology Associates, Privacy Officer at: 3330 Preston Ridge Road, Suite 300, Alpharetta, GA 30005.

With this consent, AOA 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, AOA 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 AOA 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 AOA'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, AOA may decline treatment to me.

_____ _____

Signature or Patient or Legal Guardian Date

_____ _____

Patient Name Print name of legal guardian (if applicable)