Carrboro Family Medicine, P.A
Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Carrboro Family Medicine, P.A.** 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 **Carrboro Family Medicine, P.A.** describes such uses and disclosures more completely.)

With this consent, **Carrboro Family Medicine, P.A**. may call my home/cell or other alternative location and leave a message on **voice mail** in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items, radiology reports, prescriptions, medical advice, laboratory test results or anything pertaining to my clinical care/health information.
YES___ NO____ Alternate Phone Number______________________

With this consent, if we are unable to reach you **Carrboro Family Medicine, P.A.** may call my relatives or friends and leave a message on **voice mail** or discuss **in person** in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, radiology reports, prescriptions, medical advice, laboratory test results or anything pertaining to my clinical care/ health information.
YES___ NO____

With this consent, my relatives or friends may contact **Carrboro Family Medicine, PA** and leave a message on **voice mail** or discuss **in person** in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, radiology reports, prescriptions, medical advice, laboratory test results or anything pertaining to my clinical care/ health information.
YES___ NO____

Name ________________________Relationship _______________Phone#____________________

Name ________________________Relationship _______________Phone#____________________

Name ________________________Relationship _______________Phone#____________________

Is there any information that you <u>**DO NOT**</u> wish Carrboro Family Medicine, P.A. to leave on voice mail or discuss in person with someone else? **YES_____ NO____**

If **YES** please explain what information can **Carrboro Family Medicine, P.A.** discuss/release to relatives or friends?

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I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

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Signature of Patient or Legal Guardian

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Print Patient's Name Date