Family Healthcare of Fairfax, PC

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Family Healthcare of Fairfax, PC 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 Family Healthcare of Fairfax, PC (FHF) describes such uses and disclosures more completely)

I have the right to review the Notice of Privacy Practices prior to signing this consent. FHF 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 FHF.

With this consent, FHF may send messages via portal or call my home or alternative location and leave messages on voice mail or in person in reference to any items that assist the practice in carrying out TPO. Examples of this include appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory test results, among others. With this consent, FHF 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.

I have the right to request that FHF 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 Family Healthcare of Fairfax, PC 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, FHF may decline to provide treatment to me.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

The patient, guardian or legal representative hereby authorizes the Family Healthcare of Fairfax, PC to release medical information to the following individuals:

☐ **No one except as indicated below:**

YES	NO	Name:	Relationship:
☐	☐	_____	_____
☐	☐	_____	_____
☐	☐	_____	_____
☐	☐	_____	_____

_____ _____

Patient/Guardian Signature **Date**