CULLMAN PRIMARY CARE

Patient Consent Form

I understand that as part of the provision of healthcare services, **CULLMAN PRIMARY CARE, P.C.** creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, and healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organizations is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent in writing, except where disclosures have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format are confidential and cannot be Disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy of fax of this consent is valid as this original.
3. I may revoke this consent at any time, except where information has already been released. This consent is valid until revoked by me in writing.
4. I have the right to request that the use of my Protected Health Information which is used or Disclosed for the purposes of treatment, payment or health care operations be restricted. Cullman Primary Care, P.C. is not bound by the restriction unless it is in agreement with the restriction.

_____ _____

(PATIENT'S NAME PRINTED) (DATE)

_____ _____

PATIENT'S SIGNATURE(OR GUARDIAN.IF MINOR) SSN#

_____ _____

WITNESS DATE