DOYLESTOWN MEDICAL ASSOCIATES, P.C.

HIPAA CONSENT FOR USER AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Doylestown Medical Associates, P.C. to use and disclose protected health information (PHI) about me to carry-out treatment, payments and health operation (TPO). (Doylestown Medical Associates, P.C. Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

Doylestown Medical Associates, P.C. participates in various health information exchanges where we disclose your health information, as permitted by law, to other health care providers for your treatment, or for payment or other health care operations purposes.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Doylestown Medical Associates, P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revise Notice of Privacy Practices may be obtained by forwarding a written request to Doylestown Medical Associates, P.C. Privacy Officer at 301 South Main Street, Suite 2 South, Doylestown, PA 18901.

With this consent, Doylestown Medical Associates, P.C. may call my home or other alternative location and leave a message om voice mail 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, Doylestown Medical Associates, P.C. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Doylestown Medical Associates, P.C. may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements.

I have the right to request that Doylestown Medical Associates, P.C. 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 DOYLESTOWN MEDICAL ASSOCIATES, P.C.'S use and disclosure of my PHI to carry out TPO.

I may revoke any consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior request. If I do not sign this consent, or later revoke it, DOYLESTOWN MEDICAL ASSOCIATES, P.C. may decline to provide treatment to me.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____