DOYLESTOWN MEDICAL ASSOCIATES, P.C.

HIPAA CONSENT FOR USER AND DISCLOSURE OF PROTECTD 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 treatments, payments, and health operation (TPO). (Doylestown Medical Associates, P.C. 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. 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 800 West State Street, Suite 201, Doylestown, PA 18901.

With this consent, Doylestown Medical Associates, P.C. may call my home, mail, or email to my home or alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements, insurance items and calls pertaining to my clinical care, including laboratory results, among others.

I acknowledge and read the Notice of Privacy Practices Consent and agree to the terms.

Printed Name: _____ Date of Birth: _____

Signature: _____ Date: _____

I authorize the release of information including laboratory results, radiology results, and appointment information.

I give Doylestown Medical Associates permission to speak to the following:

Name:_____ Relationship: _____ Phone Number:_____

Name:_____ Relationship: _____ Phone Number:_____

Name:_____ Relationship: _____ Phone Number:_____

I give permission to Doylestown Medical Associates to leave a message on this number:

Telephone Number: _____ ☐Home ☐Cell

May leave a detailed message ☐Yes ☐No