Patient Consent for use and disclosure of
Protected Health Information

With my consent, **Primary Care Institute,** may use and disclose protected health information (PHI) about myself to carry out treatment, payment, and healthcare operations (TPO). Please refer to **Primary Care Institute** Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the notice of privacy practices which may be obtained by forwarding a written request to **Primary Care Institute at 816 NW 13th St. Gainesville, Fl. 32604.**

With my consent, **Primary Care Institute** may call my home or other designated locations and leave a message or voice mail in reference to any items that assist the practice in carrying out TPO. These items include appointment reminders; insurance inquires, and calls pertaining to my clinical care (laboratory results, etc.).

With my consent, **Primary Care Institute** may mail any items that may assist the practice in carrying out TPO. These items include appointment reminders; patient statement, etc. and will be marked personal and confidential. I have the right to request that **Primary Care Institute** restrict how it uses or discloses my protected health information when carrying out TPO. However, this practice is not required to agree to my requested restrictions, but if it does, it is therefore bound by this agreement.

By signing this form, I give consent to **Primary Care Institute** to use and disclose of 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, **Primary Care Institute** may decline to provide treatment to me.

Signature of Patient or Legal Guardian: ____

Printed Name of Patient or Legal Guardian: ____

Patients Name: ____

Date: ____