



CARRBORO FAMILY MEDICINE CENTER, P.A.

Patient Centered. Community Based.

**PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

I hereby give my consent for Carrboro Family Medicine, P.A. 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 Carrboro Family Medicine, P.A. describes such uses and disclosures more completely.)

With this consent, Carrboro Family Medicine, P.A. may call my home/cell or other alternative location and leave a message on voice mail in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items, radiology reports, prescriptions, medical advice, laboratory test results or anything pertaining to my clinical care/health information. YES _____ NO _____ Alternate Phone Number _____

With this consent, if we are unable to reach you Carrboro Family Medicine, P.A. may call my relatives or friends and leave a message on voice mail or discuss in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, radiology reports, prescriptions, medical advice, laboratory test results or anything pertaining to my clinical care/ health information. YES _____ NO _____

With this consent, my relatives or friends may contact Carrboro Family Medicine, PA and leave a message on voice mail or discuss in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, radiology reports, prescriptions, medical advice, laboratory test results or anything pertaining to my clinical care/ health information. YES _____ NO _____

Name _____ Relationship _____ Phone# _____

Name _____ Relationship _____ Phone# _____

Name _____ Relationship _____ Phone# _____

Is there any information that you DO NOT wish Carrboro Family Medicine, P.A. to leave on voice mail or discuss in person with someone else? YES _____ NO _____

If YES please explain what information can Carrboro Family Medicine, P.A. discuss/release to relatives or friends?

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Signature of Patient or Legal Guardian _____