Middletown FamilyCare Associates

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Patient Acknowledgement of receipt of Privacy Policy

** Please read and sign this and return it to the front desk before you leave the office.

I have received a copy of the Notice of Privacy Practices from Middletown FamilyCare Associates and have been provided an opportunity to review it.

Patient Name	Date of Birth	Signature of Patient/Legal Guardian	Today's Date

Patient Consent for Use and Disclosure of Protected Health Information

Yes / No I hereby give my consent for Middletown FamilyCare to use and disclose **protected health information (PHI)** about me to carry out my **treatment, payment** and health care **operations (TPO)**. (The notice of Privacy Practices provided by Middletown FamilyCare describes such uses and disclosures more completely. **(If I do not sign this consent, or later revoke it, Middletown FamilyCare may decline to provide treatment to me.)**

I have the right to request that Middletown FamilyCare restrict how it uses or discloses my **(PHI)** to carry out my **(TPO).**

My restriction preferences are as follows:

Yes / No I authorize Middletown FamilyCare to call my **home phone** and **leave messages** regarding appointments, lab results, diagnostic results and any other healthcare information pertaining to my care.
(* If no, then it will be the patient's responsibility to call our office for all lab/diagnostic test results.)

____**Yes** I authorize Middletown FamilyCare to discuss my **TPO with a family member or caregiver:**
Person: ______________________________ Relation: ________________ Phone: ______________
(We will try to contact the patient first, and will only contact others if the patient is unavailable in case of emergency.)

____ **No** I do not authorize Middletown FamilyCare to provide my TPO to **anyone but myself**.

With this consent, Middletown FamilyCare may **mail** to my home any items that assist the practice in carrying out **treatment, payment and operations (TPO)**, such as patient statements as long as they are marked **"Personal and Confidential."**

***I also understand that it is my responsibility to keep Middletown FamilyCare Associates office up to date on my telephone numbers, address or any other insurance changes.**

I may revoke my consent in writing for future disclosures but it will not affect information already given upon my prior consent.

______________________________ ______________________________
Print Patient's Name   Print Name of Legal Guardian, if applicable

Signed by: ______________________________ ____________ ______________________________
Signature of Patient or Legal Guardian   Date   Relationship to Patient