PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Countryside Medical, P.A. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Countryside Medical, P.A.s 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 prior to signing this consent.

Countryside Medical, P.A. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Countryside Medical, P.A.'s Privacy Officer at P.O. Box 76129 Ocala, Fl, 34481. Attention Privacy Officer.

With my consent, Countryside Medical, P.A. may call my home or other designated 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, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

With my consent, Countryside Medical, P.A. may send any and all PHI to any referred and or referring physician.

With my consent Countryside Medical, P.A., may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards, cancellation letters, no show letters, and patient statements.

I have the right to request that Countryside Medical, P.A. restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Countryside Medical, P.A.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent Countryside Medical, P.A. may **decline to provide treatment to me**.

I have received, read and acknowledged the Privacy Policy of Countryside Medical, P.A.

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Signature of Patient or Legal Guardian

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Patient's Name *Date*

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Print Name of Patient or Legal Guardian