Carrico Congleton Family Practice
Privacy Consent
(HIPAA Policy)

NAME: _____ DOB: _____

PERSONAL REPRESENTATIVE

I authorize Carrico Congleton Family Practice, LLC to give my personal representative(s), as listed below, protected health information on my behalf.

Name & Relationship	Telephone number
_____	_____
_____	_____
_____	_____

Please check all that apply:
I wish to be contacted about my protected health information by:

__ Home Telephone_____
__ Cell Phone_____
__ Work Phone_____
__ Mail
__ Other_____

___YES ___NO **PERSONAL HEALTH INFORMATION & TEST RESULTS MAY BE LEFT ON VOICEMAIL**

I acknowledge that I have received a copy of the Notice of Privacy from Carrico Congleton Family Practice, LLC.

CONSENT: I HEREBY CONSENT TO Carrico Congleton Family Practice, LLC using or disclosing my protected health information (PHI) for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out health care operations. I authorize examination and any other medical service deemed necessary by health care providers or my insurance company, unless specifically requested in writing by me. This protected health information includes any personal or confidential information of a sensitive nature such as psychological, psychiatric records, substance abuse, drug or alcohol treatment or information or information pertaining to communicable diseases (including HIV status, hepatitis's, venereal disease). I understand and agree to these conditions as a patient at Carrico Congleton Family Practice, LLC.

I also understand that no test(s) will be done without my knowledge and that I must come into the office to receive HIV test results, and that the test results will be kept confidential, the extent permitted by law.

PRINT PATIENT NAME _____

PATIENT SIGNATURE _____

PERSONAL REPRESENTATIVE (if applicable) _____

WITNESS_____DATE:_____