Patient Consent form

Use of this form is optional and not required under the HIPAA privacy rule.

Peter J. Damico, MD

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Peter J. Damico, MD 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 Peter J. Damico, MD describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Peter J. Damico, MD Family Practice** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Laurel Manke, Privacy Officer.**

With this consent, **Peter J. Damico, MD Family Practice**, may call my home or other alternative 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 class pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Peter J. Damico, Family Practice**, may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, **Peter J. Damico, MD Family Practice**, may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Peter J. Damico, MD. Restrict how it uses or discloses my PHI to carry out TPO. 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 allow **Peter J. Damico MD Family Practice** to use and disclose 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, or later revoke it, **Peter J. Damico MD** may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Print Patient's Name Date

_____

Print Name of Patient or Legal Guardian, if applicable