Dublin-Macon Cardiology, P.C.
206A Hospital Drive
Dublin, Georgia 31021

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Dublin-Macon Cardiology to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Dublin-Macon Cardiology's Notice of Privacy Practices provides 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. Dublin-Macon Cardiology 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 Dublin-Macon Cardiology Privacy Officer at 206A Hospital Drive, Dublin, GA 31021.

With this consent Dublin-Macon Cardiology may call my home or other alternative locations and leave a message on voice mail or any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

With this consent Dublin-Macon Cardiology 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 Dublin-Macon Cardiology restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Dublin-Macon Cardiology'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 disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dublin-Macon Cardiology may decline to provide treatment to me.

I understand that a copy of Dublin-Macon Cardiology's Privacy Practices can be viewed and/or obtained at my request.

_____ _____
Signature of Patient or Legal Guardian Date Signed

_____ _____
Patient Name Date of Birth

_____
Print Name of Patient or Legal Guardian