Copperfield Family Medicine, P.A.

Consent for Purposes of Treatment, Payment and Healthcare Operations

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I consent to the use or disclosure of my protected health information by Copperfield Family Medicine, P.A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations (TPO) of Copperfield Family Medicine, P.A.. I understand that diagnosis or treatment of me by Drs. Arthur or Carlotta Hillert may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Copperfield Family Medicine, P.A. is not required to agree to the restrictions that I may request. However, if Copperfield Family Medicine, P.A. agrees to a restriction that I request, the restriction is binding on Copperfield Family Medicine, P.A.

I have the right to revoke this consent, in writing, at any time, except to the extent that Copperfield Family medicine, P.A. has taken action in reliance on this consent.

With this consent, Copperfield Family Medicine, P.A. 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 calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Copperfield Family Medicine, P.A. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as reminder cards and patient statements.

I understand I have a right to review Copperfield Family Medicine, P.A.'s Notice of Privacy Practices prior to signing this document. Copperfield Family Medicine, P.A.'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Copperfield Family Medicine, P.A.. The Notice of Privacy Practices for Copperfield Family Medicine, P.A. is also provided in the office. This Notice of Privacy Practices also describes my rights and Copperfield Family Medicine, P.A.'s duties with respect to my protected health information.

Copperfield Family Medicine, P.A. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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Signature of Patient or Personal Representative Date

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Printed Name of Patient or Personal Representative

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Description of Personal Representative's Authority