Midtown Healthcare | Chad James, FNP-C | 1097 Weston Dr., Ste. 3, Mt. Juliet, TN 37122

HIPAA Compliance Patient Consent Form

Our notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patients' rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you, However, such revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of information, but the practice does not have to agree with those restrictions.
- The patient has the right to revoke this consent in writing at any time, and all full disclosures will then cease.

May we leave a message on your voicemail at home, work, or cell phone related to appointments or test results? ☐ YES ☐ NO

Would you like to consent to receive SMS text messages from Midtown Healthcare? *Message and data rates may apply. ☐ YES ☐ NO
**Can provide additional information for SMS compliance consent form, upon request.

May we discuss your medical conditions with any members of your family (including test results, etc.)? ☐ YES ☐ NO

If YES to discussing information with family, please list who we are allowed to speak with below:

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

**If you would like to add additional family members, please write them on the back of this page and initial beside each name.*

Signature for consent: _____ Date: _____

Printed Name: _____ DOB: _____

Last updated 01/2025