MEDICAL ASSET GROUP, LLC
15239 AL HWY. 68W
CROSSVILLE, AL 35962

HIPAA CONSENT FORM

I _____ hereby give my consent for Crossville Family Care to use and disclose protected health information about me to carry out treatment, payment, and health care operations. (The Notice of Privacy Practices provided by describes such uses and disclosures more completely.)

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect my privacy. I have the right to review the Notice of Privacy Practices prior to my signing this content. Crossville Family Care 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 the address above.

With this consent, Crossville Family Care may communicate with me by telephone, mail, email, voicemail or other alternative types of communication in reference to any items that assist the practice in carrying out health care operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory test results, among others.

I have the right to request that Crossville Family Care restrict how it uses or discloses my personal health information to conduct health care operations. The practice is not required to agree to my requested restrictions, but if it does, it is bound by the agreement.

By signing this form, I am consenting to allow Crossville Family Care to use and disclose my personal health information to conduct health care operations.

The content of calls initiated by patient or representative of patient to subscriber or answering service of subscriber may be communicated to appropriate personnel of subscriber by conventional telephone, text, email, or fax communication.

I may revoke my consent in writing except that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Crossville Family Care may decline to provide treatment to me.

Print Patients Name: _____ **Date of Birth: _____**

Signed by: _____ **Date: _____**

(Patient or Guardian)

Relationship to Patient: _____ **Phone Number: _____**