GWINNETT INTERNAL MEDICINE ASSOCIATES, LLC

PATEINT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Gwinnett Internal Medicine Associates, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Gwinnett Internal Medicine Associates, LLC Notice of Privacy Practices provides a more complete description of such uses and disclosure.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Gwinnett Internal Medicine Associates, LLC 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 Gwinnett Internal Medicine Associates, LLC attn: Privacy Official at: 601-A, Old Norcross Road, Lawrenceville, GA 30046

With this consent, Gwinnett Internal Medicine Associates, LLC 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 results among others.

With this consent, Gwinnett Internal Medicine Associates, LLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders.

I have the right to request that Gwinnett Internal Medicine Associates, LLC 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. Any restrictions must be placed in written format and presented to the Privacy Officer at Gwinnett Internal Medicine Associates, LLC. Verbal changes will not be upheld. By signing this form I am consenting to Gwinnett Internal Medicine Associates, LLC use and disclosure of my Protected Health Information to carry out treatment, payment and healthcare operations.

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, Gwinnett Internal Medicine Associates, LLC may decline to provide treatment to me.

_____ _____

Patient or Legal Guardian (Print Name) Date

_____

Signature of Patient or Legal Guardian