

Montgomery Family Medicine

8190 Seaton Place ♦ PO Box 240369
Montgomery, AL 36124

CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

I AUTHORIZE Montgomery Family Medicine and staff to perform medical treatment.

I CONSENT to Montgomery Family Medicine’s use and disclosure of all individually identifiable personal health, financial and demographic information (known as Protected Health Information or PHI) for the purposes of:

- ♦ providing medical treatment
- ♦ obtaining payment and reimbursement
- ♦ requesting healthcare services from other providers
- ♦ cooperating with other providers in my medical treatment
- ♦ and doing all other things directly related to providing healthcare to me.

The above purposes and all other uses are known collectively as Treatment, Payment and Other healthcare operations or TPO.

I have been given the opportunity to review and agree with the terms and conditions of Montgomery Family Medicine’s Patient Information Protection Plan. Montgomery Family Medicine reserves the right to change these practices. (The most recent version of our Patient Information Protection Plan is posted and available in our lobby and posted on our web site.)

I understand my rights to restrict the use and disclosure of PHI when used to carry out TPO and that Montgomery Family Medicine is not required to agree to any requested restrictions. Montgomery Family Medicine is bound by any restrictions I request and they agree to. **Only an officer of the practice may agree to restrict the use of PHI or change how PHI is normally used to carry out TPO.** I understand that I may revoke this consent at any time and that the revocation will not impact PHI used for TPO already undertaken.

I understand that should I choose not to consent to the terms and conditions of Montgomery Family Medicine’s Patient Information Protection Plan, or restrict the use of my PHI to the extent it hampers TPO, the practice has the right to withhold treatment except where required by law.

I AUTHORIZE any other physician or healthcare facility to provide upon request any PHI to Montgomery Family Medicine when needed for the purposes of TPO.

Patient Name: _____

Patient's Signature: _____ Date _____

Insured or Guardian's Signature: _____ Date _____

“I *revoke* my prior consent.” Signed _____ Date _____ Staff witness: _____