Internal Medicine Physicians of the North Shore

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Internal Medicine Physicians of the North Shore, LLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the office Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The practice reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by verbal request to the Privacy Officer at 27 Centennial Dr., Peabody, MA. 01960

With my consent, Internal Medicine Physicians of the North Shore, LLC , may call my home or other designated location and leave a message on voicemail, or in person, in reference to any items and any call pertaining to my clinical care, laboratory results among others.

With my consent, Internal Medicine Physicians of the North Shore, LLC may mail to my home or other designated location, items that assist the practice in carrying out TPO, such as appointment reminders cards and patient statements as long as they are sealed appropriately.

With my consent, the practice may call my home for appointment reminders and abnormal test results. I have the right to request that the practice restrict how it uses or discloses my protected Health Information to carry out treatment, payment and healthcare operations, however, the practice is not required to agree to my requested restrictions, but if it does, it is bind by my agreement.

By signing this form, I am consenting to physician's use and disclosure of my protected health information.

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, Internal Medicine Physicians of the North Shore, LLC may decline to provide treatment to me.

Signature of Patient : _____ Date:_____

Patient's Name: _____