

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH  
INFORMATION- Receipt of Notice of Privacy Practices**

With my consent, University Family Medicine Center, PA may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to University Family Medicine Center, PA's 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. University Family Medicine Center, PA 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 University Family Medicine Center, PA Privacy Officer, Janet Burns, at 10055 University Blvd., Orlando, FL 32817.

With my consent, University Family Medicine Center, PA may call my home or other designated location and leave a message on a 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 call pertaining to my clinical care, including laboratory results among others.

With my consent, University Family Medicine Center, PA may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, and they will be marked personal and confidential.

With my consent, University Family Medicine Center, PA may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that University Family Medicine Center, PA 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.

By signing this form, I am consenting to University Family Medicine Center, PA's uses and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already disclosures in reliance upon my prior consent. If I do not sign this consent, University Family Medicine Center, PA may decline to provide treatment to me.

I hereby acknowledge I have received a copy of the privacy notice of UFMC, PA.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

9/2013