PATIENT CONSENT AND AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

By signing below, you hereby consent and authorize Albany Internal Medicine and Privia Medical Group Georgia to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose of treatment, payment and health care operations. You may refuse to sign this consent form but by doing so we may not be able to treat you.

You should read the Notice of Privacy Practices for protected health information made available to you by us before signing this Consent. The terms of the Notice of Privacy Practices may change from time to time, and you may obtain a revised copy of it by asking s for a copy.

Your "protected health information" means all health information and medical records, including your demographic information, collected from you and created or received by your physician, another health care provider, a health plan, your employer or a health care claims clearinghouse. Additionally, I understand this authorization includes release of all medical records, which may include information regarding Human Immunodeficiency Virus (HIV), psychiatric and/or drug/alcohol abuse, Venereal disease, and or any other statutory protected disease. I understand that I may revoke this authorization and consent in writing at any time except to the extent that Albany Internal Medicine has acted in reliance upon this authorization. This protected health information relates to your past, present or future physical or mental health or condition and identifies you, or there is a reasonable basis to believe the information identify you.

If someone calls or visits and asks about you, can we acknowledge that you are here?
Yes _____ No_____

I wish to be contacted in the following manner (check all that apply):

- ☐ Home Telephone: _____________________
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Work Telephone: ______________________
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Written Telephone: _____________________
  - ☐ OK to mail to my home address
  - ☐ OK to mail to my work/office address

I hereby give permission to the person(s) listed below to authorize treatment, attend examinations, and to receive information about the care of the below named patient. This includes but is not limited to: information about the patient's general medical condition and diagnosis (including treatment and payment options), access to medical records (protected health information), prescription pick-up, and the ability to set appointments.

1: _____________________________________ Relationship to you: ______________________________________

2: _____________________________________ Relationship to you: ______________________________________

3: _____________________________________ Relationship to you: ______________________________________

_______________________________________ _________________ ___________________
Patient Signature Date Medical Record Number

____
Albany Internal Medicine Witness Signature

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