PULMONOLOGY ASSOCIATES, INC.

Breathe easier. Live better.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Pulmonology Associates, Inc. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Pulmonology Associates, Inc. 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 Pulmonology Associates, Inc., 100 Lancaster Ave., Suite 230, Wynnewood, PA 19096.

With this consent, Pulmonology Associates, Inc. may call my home or other alternative location and leave a message on voice mail or in person regarding appointment reminders, insurance items, laboratory test results, and other clinical care matters.

With this consent, Pulmonology Associates, Inc. may mail items that assist the practice in carrying out TPO, such as appointment reminders and patient statements marked "Personal and Confidential."

With this consent, Pulmonology Associates, Inc. may email items that assist the practice in carrying out TPO. I have the right to request restrictions on the use or disclosure of my PHI to carry out TPO. The practice is not required to agree to requested restrictions, but if it does, it is bound by that agreement.

By signing this form, I am consenting to allow Pulmonology Associates, Inc. to use and disclose my PHI to carry out TPO.

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, Pulmonology Associates, Inc. may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Print Name of Legal Guardian, if applicable

_____ _____

Print Patient's Name Relationship to Patient

_____

Date

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Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand Pulmonology Associates Inc. ***Notice of Privacy Practices*** containing a description of the uses and disclosures of my health information. I further understand that Pulmonology Associates Inc. may update its Notice of Privacy Practices at any time and that I may receive an updated copy by submitting a request in writing.

Printed Patient Name

Patient Signature Date Date

I permit the following to receive and give information on my behalf:

_____ _____

_____ _____

_____ _____

If completed by patient's personal representative, please print name and sign below.

Printed Patient Personal Representative Name Relationship to Patient

Patient Representative Signature Date

For Pulmonology Associates Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative.

Pulmonology Associates Inc. made a good faith effort to obtain patient's written acknowledgement of the ***Notice of Privacy Practices*** but was unable to do so for the reasons documented below:

☐ Patient or patient's personal representative refused to sign

☐ Patient or patient's personal representative unable to sign

☐ Other: _____ _____

Employee Printed Name Employee Signature