



## Patient Content for Use and Disclosure of Protected Health Information

The individual whose signature appears below hereby attests to the following statement:

With my consent, Pulmonary & Sleep Consultants may use and disclose protected health information (PHI) about me to carry out treatment, payments and healthcare operations (TPO). Please refer to Pulmonary & Sleep Consultants Notice of Privacy Practices for a more complete description of such uses and disclosures.

With my consent, Pulmonary & Sleep Consultants may disclose my PHI to the following individuals (family, relatives, or friends) who may assist in my care.

Name	Relationship	Best Number to reach

I have the right to review the Notice of Privacy Practices prior to signing the consent. Pulmonary & Sleep Consultants, reserves the right to revise its Notice of Privacy Practices at any time. A written copy of our Notice of Privacy Practices may be obtained by forwarding a written request to our office.

### **CONSENT FOR CALLS TO PROVIDED CONTACT NUMBER**

With my consent, Pulmonary & Sleep Consultants, may call my home or other designated location and leave message on my voice mail or with a person listed above in reference to any item that may assist Pulmonary & Sleep Consultants, in carrying out TPO, such as appointment reminder, insurance items and any call pertaining to my clinical care, including radiology, laboratory results, among others.

### **CONSENT FOR MAIL**

With my consent, Pulmonary & Sleep Consultants, may mail to my home or other designated location any item that may assist Pulmonary & Sleep Consultants, in carrying out TPO such as appointment reminder cards and patient statements.

I have the right to request that Pulmonary & Sleep Consultants, restricts how it uses or discloses my PHI to carry out the TPO, However, Pulmonary & Sleep Consultants is not required to agree to my requested restrictions. I may revoke my consent in writing except to the extent that Pulmonary & Sleep Consultants has already made disclosure in reliance upon my prior consent.

By signing this form, I am consenting to Pulmonary & Sleep Consultants, use and disclosure of my PHI to carry out TPO.

**If I do not sign this consent, Pulmonary & Sleep Consultants, may decline to provide services to me.**

Signed by: \_\_\_\_\_

Date: \_\_\_\_\_