REAL FAMILY MEDICINE, PLLC
PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Real Family Medicine, PLLC ("the Practice") to use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment, and Healthcare Operations (TPO). The Notice of Privacy Practices provided to me by the Practice describes such uses and disclosures and I have had an opportunity to review the Notice prior to signing this consent. The Practice reserves the right to revise its Notice of Privacy Practices at any time and I understand that I may obtain a copy of the revised Notice of Privacy Practices by reviewing the revised notice on the Practice's website at: realfamilymedicine.com

With this consent, the Practice may call my home, cell or other number designated by me and leave a message on voice mail or in person in reference to any items that assist the Practice in carrying out TPO, such as appointment and payment reminders, and any call pertaining to my clinical care, including laboratory results among others.

With this consent, the Practice may text me on my cell or other number designated by me in reference to any items that assist the Practice in carrying out TPO, such as appointment and payment reminders, and items pertaining to my clinical care, including laboratory results among others.

With this consent, the Practice may send an email to me at the email address provided by me with any items that assist the Practice in carrying out TPO, such as appointment reminders, and payment/billing information. I have the right to request that the Practice restrict how it uses or discloses my PHI to carry out TPO. The Practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

I understand that email, voicemail, and standard SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email, voicemail, and standard SMS messaging regarding my medical care might be intercepted and either listened to or read by a third party. By signing this form, I am consenting to the Practice's use and disclosure of my PHI to carry out TPO using unencrypted means.

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, the Practice may decline to provide treatment to me.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Print Patient's Name

_____
Print Name of Legal Guardian (if applicable)

(Patient/guardian must be provided with a signed copy of this form)