905 29th Ave Marion, Iowa 52302 Phone: 319-826-6374 Fax: 319-826-6376

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Infinity Medical Clinic, P.C. (IMC) to use and disclose protected health information (PHI) about me to carry out treatment, payment and health operations (TPO). (The notice of Privacy Practices provided by IMC describes such uses and discloses more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. IMC reserves the right to revise its Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Brandi Van De Vegte
905 29th Ave, Marion, IA 52302, (319)826-6374.

With this consent, IMC may call or e-mail my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including but not limited to Laboratory test results, X-ray results, etc.

With this consent, IMC may e-mail or mail to my home or other alternative or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that IMC restrict how it uses or discloses my PHI to carry out TPO. 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 allow IMC to use and disclose m 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, IMC may decline to provide treatment to me.

I consent to have the following people to receive calls and be giving any medical information that pertains to my care.

____________________________ ____________________________

____________________________ ____________________________

____________________________ ____________________________

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

Date