FIRST HEALTH MEDICAL CENTER LLC.

Acknowledgment of Receipt of Notice of Privacy Practices

Purpose of consent: By signing this form, you carry consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

TREATMENT: The practice may release/obtain any and all your records to/from other healthcare professionals, physicians, and hospitals providing care to you at any time.

PAYMENT ACTIVITIES: The practice may release any and all your records to Medicare, Medicaid, any insurance company, third-party payer, or managed care Company.

HEALTHCARE OPERATIONS: We may attempt to contact you at the phone number (s) you have provided to us and we may leave a message on your answering machine regarding a scheduled appointment or test results. In accordance with the Federal Government privacy rules implemented through the Healthcare Portability Act (HIPAA), you have the right to read out the Notice of Privacy Practices before you decide whether to sign the consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices, which will contain changes and may apply to the health information that we maintain. You may obtain a copy of our notice of Privacy Practices, including any revisions, at any time by contacting: First Health Medical Center.

RIGHT TO REVOKE: You have the right to revoke this consent at any time by giving us a written notice of your revocation submitted to the office. Please understand that the revocation of this consent will NOT affect any action we took in reliance on this consent before we received revocation and that we decide to treat you or continue to treat you if you revoke this consent.

I have had the full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent for your use and disclosure of my protected health information to carry out treatment, payment and activities, and healthcare options.

PRINTED NAME: _____

SIGNATURE: _____ **Date:** _____

****I give my consent for my physician or his staff to discuss my condition only with myself and the family members or individuals listed below****

1) _____ **2)** _____ **3)** _____

4) _____ **5)** _____ **6)** _____