# Patient Consent for Use and Disclosure of Protected Health Information

I herby give my consent for Internal Medicine Associates of Johns Creek, Inc to use and disclose my protected health information about me to carry out treatment, payment and healthcare operations.

You have the right to review the notices of privacy practices prior to signing this consent. Internal Medicine Associates reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to Internal Medicine Associates (Attn: Carol Walker) at the below address

With this consent, Internal Medicine Associates may call my home or other alternative locations and leave a message on a voice mail or a person in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appt reminder phone calls or cards, and patient statements, as long as they are marked as personal and confidential.

You have the right to request the Internal Medicine Associates restrict how it uses or discloses my protected health information to carry out my treatment, payment, or healthcare operations. However, Internal Medicine Associates is not required to agree to accept your request. If Internal Medicine Associates agrees to accept your request, Internal Medicine Associates will be bound by the request. By signing this form, you are consenting to Internal Medicine Associates to use and disclose of my Protected Health Information.

You may revoke your consent in writing expect to the extent that the practice has already made disclosure and reliance upon your prior consent, If you do not consent to the Protected Health Information, or later revoke, Internal Medicine Associates may decline to provide treatment.

______________________ ______________________
(Print Patient Name) (DOB)

______________________ ______________________
(Signed Signature) (Date)

**Internal Medicine Associates of Johns Creek**
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