



Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Peachtree Hematology-Oncology Consultants, P.C. its physicians and legal entities to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (Peachtree Hematology-Oncology Consultants, P.C.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent (a copy is in the reception area and a copy may be requested from the receptionist). Peachtree Hematology-Oncology Consultants, P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request.

With this consent, Peachtree Hematology-Oncology Consultants, P.C. may call my home or mail to my home or other alternative location any items that assist the practice in carrying out TPO such as appointment reminders, insurance items or patient statements, as well as any calls, or printed information pertaining to my clinical care, including laboratory results among others.

I have the right to request that Peachtree Hematology-Oncology Consultants, P.C. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound to this agreement.

By signing this form, I am consenting to Peachtree Hematology-Oncology Consultants, P.C.'s use and disclosure of my PHI to carry out TPO. I hereby release Peachtree Hematology-Oncology Consultants, P.C. and its agents and employees from any and all liabilities, damages, losses, claims and expenses which may arise from the release of the information authorized above.

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, Peachtree Hematology-Oncology Consultants, P.C. may decline to provide treatment to me. A photocopy of this document shall be as valid as the original.

Signature of Patient or Legal Guardian

Relationship to Patient

Print Patient's Full Name or Legal Guardian

Date