

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

[X] I, _____, have received a copy of **DIABETES AND**
(**PRINT** name of Patient or Legal Guardian)

ENDOCRINOLOGY ASSOCIATES, P.C.'s Notice of Privacy Practices.

Print Patient's Name

Signature of Patient or Legal Guardian

Date

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Note: Execution of this Patient Consent portion of the form is OPTIONAL AND NOT REQUIRED under the Privacy Rule.

I hereby give my consent for Diabetes and Endocrinology Associates, P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Diabetes and Endocrinology Associates, 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. Diabetes and Endocrinology Associates, P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Diabetes and Endocrinology Associates, P.C. Privacy Officer at **2665 N. Decatur Rd., Suite 520 Decatur, GA 30033**.

With this consent, Diabetes and Endocrinology Associates, P.C. may call my home or other alternative location 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 reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Diabetes and Endocrinology Associates, P.C. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Diabetes and Endocrinology Associates, P.C. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Diabetes and Endocrinology Associates, 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 by this agreement. By signing this form, I am consenting to Diabetes and Endocrinology Associates, P.C.'s use and disclosure of my 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, Diabetes and Endocrinology Associates, P.C. may decline to provide treatment to me.

PRINT Patient's Name

Signature of Patient or Legal Guardian

Date

PRINT Name of Legal Guardian