CAROLINA SPORTS MEDICINE

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, CAROLINA SPORTS MEDICINE, may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to CAROLINA SPORTS MEDICINE Notice of Privacy Practices for 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. CAROLINA SPORTS MEDICINE 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 to CAROLINA SPORTS MEDICINE, Privacy Officer, at 1717 Shipyard Blvd., Suite 350, Wilmington, NC 28403, 910-799-0110.

With my consent, CAROLINA SPORTS MEDICINE may call my home or other designated 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 call pertaining to my clinical care, including laboratory results among others.

With my consent, CAROLINA SPORTS MEDICINE may mail to my home or other designated 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 my consent, CAROLINA SPORTS MEDICINE may e-mail to me appointment reminder cards and patient statements. I have the right to request that CAROLINA SPORTS MEDICINE restricts 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 CAROLINA SPORTS MEDICINE 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, CAROLINA SPORTS MEDICINE may decline to provide treatment to me.

_____ Date: _____

Signature of Patient or Legal Guardian

_____

Patient's Name

_____

Print Name of Patient or Legal Guardian