ACCESSIBLE MEDICAL CARE CENTERS

Surgical Wellness Center
Family Wellness Center
Metro Surgical Center
Dominion Surgical Center
Laser Enhancement Center

PATIENT CONSENT FOR USE AND DISCLOSURE OR PROTECTED HEALTH INFORMATION

With my consent, *Accessible Medical Care* may use and disclose **Protected Health Information (PHI)** about me to carry our **Treatment, Payment and healthcare Operations** (TPO). Please refer to Accessible Medical Care's 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. *Accessible Medical Care* 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 Accessible Medical Care's, Privacy Officer at 1010 Wayne Ave., Suite 410/415, Silver Spring, MD 20910 or 722-A Grant St., Herndon, Va 20170.

With my consent, *Accessible Medical Care* 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, *Accessible Medical Care* may mail to my home or other designated location any items that the practice is carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, *Accessible Medical Care* may e-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. I have the right to request that Accessible Medical Care 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 *Accessible Medical Care's* use and disclosures 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, Accessible Medical Care may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Date

Patient's Name

Print Name of Patient or Legal Guardian