Lexington Family Physicians, PA

Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Lexington Family Physicians, P.A. or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing the consent. Requesting a Restriction on the Use of Disclosure of Your Information.

You may request a restriction on the use or disclosure of your protected health information.

Lexington Family Physicians, P.A. agrees to your request, the restriction will be binding on the practice. Use or disclosure or protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Lexington Family Physicians, P.A. reserves the right to modify the privacy practices outline in the notice.

Signature

I have read the Notice of Privacy Practices and I have reviewed this consent form. I give my permission to Lexington Family Physicians, P.A. to use and disclose my health information I accordance with it. This consent is valid until revoked or other wise amended in writhing by both parties.

____ Acct. #_____________
Name of Patient (Print or Type)

____
Signature of Patient

____
Date

____
Signature of Patient Representative

____
Relationship of Patient Representative to Patient

Lexington Family Physicians, PA

Standard Authorization of Use and Disclosure of Protected Health Information-Including Internal Use

Information To Be Used or Disclosed

Information covered by this authorization includes:

Periodic Test Results______________________________

Purpose of External Disclosure

Information listed above will be disclosed for the following purposes:

Communication of Test Results_______________________

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

Lexington Family Physicians, P.A.
Name of organization

Persons to Whom Information May Be Disclosed

Information described above may be disclosed to:

____
Name of person/organization

____
Name of person/organization

Expiration Date of Authorization

This authorization is effective until revoked or terminated by the patient or patient's personal representative.

Right To Terminate or Revoke Authorization

You may revoke or terminate this by submitting a written revocation to Lexington Family Physicians, P.A. . You should contact the Office to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be re-disclosed. The privacy of this information may not be protected under the federal privacy regulations.

Rights of the Individual

- You may inspect or copy information that is used or disclosed under this authorization.
- You may refuse to sign this authorization.

Effect of Refusing Authorization

If you refuse to sign this authorization, we will not deny you any treatment that is covered by your general consent to the use and disclosure of protected health information for purposed of treatment, payment, or supporting the day-to day operations of the practice.

Remuneration

Lexington Family Physicians, P.A. will not receive remuneration for disclosures permitted by this authorization.

Signature

____
Name of Patient (Print or Type)

____
Signature of Patient

____
Date

____
Signature of Patient Representative

____
Relationship of Patient Representative to Patient