PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I give my consent for Lexington Family Physicians, P.A. to use and disclose my Protected Health Information for the purpose of:

1. Treatment- LFP will provide your Health Information to any provider who has treated or is currently treating any medical or psychological conditions(s) you may have.
2. Payment- LFP will provide your Health Information to any entity who may require it in order to pay for treatment rendered in this office.
3. Healthcare Operations- Unless specifically excluded, LFP is allowed to Call, Mail or Email, to any phone number, mail, or email address you provided and leave a message or speak to a person who has access to these mediums regarding the following:
    - Appointment reminders
    - Healthcare Insurance issues
    - Laboratory results
    - Billing/Collection issues
    - Any other Clinical care

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to (Lexington Family Physicians, PA 102 West Medical Park Drive, Lexington, NC 27292). I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my personal health information have acted in reliance upon this authorization.

Person to Whom Information May Be Disclosed: **(Please provide relationship and phone #)**

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PRINT PATIENT NAME _____ BIRTHDATE _____

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE