Georgia Internal Medicine Partners, LLC

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DIPLOMATE
American Board of Internal Medicine

Patient Name: _____ Date of Birth: _____

Consent

I hereby authorize and concede to examinations and treatments, as well as the release of medical information to my insurance companies, claim representatives, adjustor, and other physicians by Georgia Internal Medicine. I understand that my demographic information is stored in the Allscripts Data Repository.

I acknowledge by signing below that the Notice of Privacy Practices (HIPAA) and notice of Individual Rights are posted and that I have read, or have had the opportunity to read, and understand the notice. I understand that I can rescind my privacy choices at any time.

Appointment Reminders and Lab Results

As a service to our patients, we routinely phone your home to remind you of your upcoming appointment and to call with lab results or test results.

We need to know:

A) May we contact you in this manner to remind you of your appointment or results?

☐ Yes ☐ No

B) If there is no answer, may we leave this information on your answering machine?

☐ Yes ☐ No

C) If you are not available, may we leave this information with the person answering the phone?

☐ Yes ☐ No

Discussion of Your Protected Health Information

By law, we are not allowed to discuss your protected health information with anyone else. Is there anyone with whom we may discuss your protected health information?

Yes, you may discuss my protected health information with the following people:

_____ _____

_____ _____

_____ _____

NAME RELATION

If you choose for your information not to be discussed with anyone, please just write NO ONE on one of the lines above.

Patient/Responsible Party Signature _____ Date _____