Family Practice Group, PC
11 Water St, Ste 1-A
Arlington, MA 02476
781-648-9700

PATIENT CONSENT FORM
For Use and Disclosure of Protected Health Information

I hereby give my consent for Family Practice Group, PC (FPG) to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). [The Notice of Privacy Practices provided by FPG describes such uses and disclosures more completely.]

I have the right to review the Notice of Privacy Practices prior to signing this consent. FPG 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 "Practice Administrator" at the above address.

With this consent, FPG may call my home or other alternative 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 calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, FPG may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, FPG may email to my home or other alternative 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 FPG restrict how it uses or discloses my PHI to carry out TPO. 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 allow FPG to use and disclose 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, or later revoke it, FPG may decline to provider treatment to me.

Signed by:_____ Date:_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name — Patient's Date of Birth

_____ _____
Print Name of Legal Guardian, if applicable — Relationship to Patient