1878 Jeff Road
Suite G
Huntsville, AL 35806
Office: 256.428.0444
Fax: 256.428.0447
www.allmanfamilymedicine.com

Receipt of Privacy Practices; Consent to Use/Disclosure of Protected Health Information (PHI)

You will find a copy of our privacy practices posted in the lobby and in each exam room. If you would like a copy for your own records, please check here. _____

I, _____, was offered a copy of Allman Family Medicine's Privacy Practices Notification. Allman Family Medicine may revise its notification at any time. I understand that a copy is always available at my request. By signing this document I acknowledge that I have read, understand and agree to the terms of this consent. Further, I hereby consent and authorize Allman Family Medicine to use or disclose my PHI in conjunction with Allman Family Medicine's treatment, payment or healthcare option in accordance with the terms of this consent.

_____ _____

Signature of Patient/Guardian **Date**

Further I hereby authorize and give my consent to Allman Family Medicine to leave messages on my answering machine/voicemail for the following (check all that apply)

Appointment reminders ____ **Prescription Refills** ____

Medical Information ____ **Test Results** ____

Insurance/Payment Issues ____ **Mail** ____

I further authorize and give consent to Allman Family Medicine to communicate any of my PHI to the following person/persons:

Name	**Relationship**

_____ _____

Signature of Patient/Guardian **Date**