ATLANTA NEUROLOGY, P.C.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Atlanta Neurology, P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care options (TPO). I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that over time, the Notice of Privacy Practices may change and that I have the right to obtain any revised Privacy Notice, if requested. Atlanta Neurology, P. C. has permission to contact me via telephone, mail, or e-mail based on the information I have provided in reference to any items that assist in carrying out TPO (i.e. appointment reminders, insurance details, clinical care such as test results).

Check one:

☐ I give permission for providers and staff to leave detailed voice messages if I am unable to answer the telephone.

☐ I do not wish to receive detailed voice messages and prefer to be contacted directly.

I understand that I have the right to request that Atlanta Neurology, P. C. restrict how my health information is used/and or disclosed. I also have the right to revoke this consent, in writing, at any time (cannot be retroactive).

I give my consent for Atlanta Neurology, P.C. provider and staff to discuss my medical condition(s), treatment(s), test result(s), and any other pertinent information regarding my care with the following person(s) (i.e. primary care doctor, spouse, relative, friend, legal guardian, etc.).

List Name(s) and relationship to patient:

_____
_____
_____
_____
_____
_____

_____ _____

Signature of Patient or Legal Guardian/Printed Patient Name Date