MAIN STREET MEDICAL, P.C.

MAIN STREET MEDICAL, P.C. HAS MADE THEIR PRIVACY POLICIES AVAILABLE TO ME, BY POSTING THE INFORMATION IN THE OFFICE, AND WITH OTHER LAMINATED COPIES OF THE POLICIES WHICH I MAY BORROW TO READ.

IF I HAVE ANY OTHER QUESTIONS, I MAY CONTACT THE PRIVACY OFFICER, AT 843-681-3777 DURING REGULAR BUSINESS HOURS.

PATIENT SIGNATURE: _____

DATE: _____

Patient consent form

Main Street Medical

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Main Street Medical to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Main Street Medical 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 the Practice Manager at Main Street Medical, 93 Main St, Hilton Head, SC 29926.

With this consent, Main Street Medical 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, Main Street Medical 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 as long as they are marked "Personal and Confidential."

With this consent, Main Street Medical may e-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. I have the right to request that Main Street Medical 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 Main Street Medical 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, Main Street Medical may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable