PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, JENNIFER CAUDILL, MD PLLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations. Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have been given the opportunity to review the Notice of Privacy Practices prior to signing this consent. Our office 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 office of JENNIFER CAUDILL, MD PLLC.

With my consent, the office may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. Additionally, with my consent, you may mail to my home appointment reminder letters and patient statements.

* ADDENDUM: I give special permission to the person(s) named and relationship listed below to receive medical information regarding my care and treatment in this office.

_____ _____

_____ _____

By signing this form, I am consenting to the above referenced office's use and disclosure of my Protected Health Information (PHI) to carry out treatment, payment and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent. If I do not sign this consent, JENNIFER CAUDILL, MD may decline to provide treatment to me.

_____ _____

Signature of patient or legal guardian Date

_____

Print name of patient