Patient Consent for Confidential Communication Regarding Protected Health Information

This is my consent for Infectious Disease Specialists of North Alabama and Scott D. Parker MD LLC to use and disclose my protected health information to carry out treatment, payment, and healthcare operations. This is my acknowledgement that I may view Scott D. Parker MD LLC and Infectious Disease Specialists of North Alabama Notice of Privacy Practices.

This is my consent for Infectious Disease Specialists of North Alabama (IDSONA) and Scott D. Parker MD LLC to: (please initial by each)

_____Call my home and leave a message on voicemail or in person to remind me of appointments, or obtain insurance information.
_____Call and leave reports of my clinical care; lab results.
_____Mail items that assist in carrying out my treatment, payment, or health operations, such as Appointment reminder card and patient statements to:
_____my home
_____other designated location:_____

_____

This is my consent for information regarding my general health and treatment to be discussed with the following people in the event that I am unavailable or in case of an emergency.

_____

_____

_____

By signing this form, I am consenting to Infectious Disease Specialists of North Alabama and Scott D. Parker MD LLC's use and disclosure of my protected health information to carry out treatment, payment, and healthcare operations. I understand that I will be responsible for any collection fees for unpaid account balances. I may revoke my consent in writing except on those disclosures made prior to my consent. I understand that Infectious Disease Specialists of North Alabama and Scott D. Parker MD LLC reserve the right to refuse to treat me if I do not sign this consent form.

_____ _____
Patient's Name Date

_____ _____
Signature of Patient or Legal Guardian Print Name of Patient or Legal Guardian

_____ _____
Witness Date