Crabapple Family Medicine PC
Madhavi Devaraju MD

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Crabapple Family Medicine PC and Madhavi Devaraju MD to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by Crabapple Family Medicine PC and Madhavi Devaraju MD describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Crabapple Family Medicine PC 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 Madhavi Devaraju MD and Crabapple Family Medicine PC
With this consent, a representative of Crabapple Family Medicine PC 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. This consent provides Crabapple Family Medicine PC the to ability to obtain pharmaceutical records from a national data base that may have medical information from providers other than Crabapple Family Medicine PC or Madhavi Devaraju MD

With this consent, Crabapple Family Medicine PC 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, Crabapple Family Medicine PC 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 Crabapple Family Medicine PC 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 Crabapple Family Medicine PC 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 , Crabapple Family Medicine PC may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

_________________________________   _______________________
Print Patient's Name   Date

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Print Name of Patient or Legal Guardian, if applicable

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