FORM 4

PHILADELPHIA HEALTH ASSOCIATES
ADULT MEDICINE, P.C.
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Patient Consent for Use and Disclosure of Protected Health Information and Communication from PHA-Adult Medicine about Medical Information

I hereby give my consent for Philadelphia Health Associates - Adult Medicine, P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Philadelphia Health Associates - Adult Medicine's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Philadelphia Health Associates - Adult Medicine reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the practice's Privacy Officer.

In general, the Health Insurance Portability & Accountability Act (HIPAA) privacy rule gives me the right to request a restriction on uses and disclosures of my protected health information (PHI). Also, I have the right to request confidential communications or that a communication of PHI be made by alternative means. **I wish to be contacted in the following manner (check all that apply):**

Home Telephone___________________________
O.K. to leave message with detailed information
Leave message with call-back number only

Written Communication
O.K. to mail to my home address
O.K. to mail to my work/office address
O.K. to fax to home/work/office

Work Telephone___________________________
O.K. to leave message with detailed information
Leave message with call-back number only

Utility Bill Forms (electric, gas, phone, water)
(Needs authorization signed prior to form being completed.)

Other **(Family Members/Caregiver to whom we can talk with about your medical condition)**
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However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement. By signing this form, I am consenting to Philadelphia Health Associates - Adult Medicine's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to extent that the practice has already made disclosures in reliance upon my prior request. **If I do not sign this consent, or later revoke it, Philadelphia Health Associates - Adult Medicine may decline to provide treatment to me.**

____ _____________________
(Signature of Patient or Legal Guardian) **(Date)**

_________________________________ __________________________ ____________________
(Print Patient's Name or Legal Guardian) **Relationship to patient** **(Date)**