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**FORM 3**

**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).

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 is made by alternative means. The practice is not required to agree to my requested restrictions if such restrictions inhibit ability to carry out TPO; otherwise, it is bound by this agreement. **I wish to be contacted in the following manner (check all that apply):**

**Home Telephone**

- O.K. to leave message with DETAIL information
- Leave message with call-back number ONLY

I want **written communication**

- MAIL to my home
- FAX to home
- MAIL to work
- FAX to work

**Work Telephone**     

- leave message with DETAIL information
- Leave message with call-back number ONLY

**In the event I cannot be reached, I give permission to release information to the following:**

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____

PLEASE TURN OVER AND COMPLETE OTHER SIDE

