Quality Internal Medicine

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Quality Internal Medicine, PLLC/ Oasis Internal Medicine, PLLC (collectively "QIM") to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (QIM'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. QIM 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: Quality Internal Medicine, Privacy Officer, 1860 Town Center Drive Suite 255, Reston, VA 20190

With this consent, QIM may call my (please circle which apply)

home (#_____) **work** (#_____) **cell phone**(#_____)

and leave a message in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, billing and insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, QIM may mail to my address(es) at (please circle which apply):

Home/work/other _____

_____

_____

Please indicate with a #1 your MOST PREFERRED way for us to contact you above.

If you would like to communicate with us electronically, via the internet, in a secure fashion, please sign up to use our Patient Portal by providing your email address to establish this: **Email Address*****_____

***** Your email address is only needed if you want your Healow patient portal activated to communicate with our practice in a HIPAA secure way. We do NOT communicate with patients via email because it is not encrypted and it does not protect your patient privacy. The patient portal is the only HIPAA compliant internet based communication medium we use.

With this consent, QIM may contact my **emergency contact**: **Name**_____ **Phone**_____ **Relation**_____

I have the right to request that QIM restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by the agreement. By signing this form, I am consenting to QIM's use and disclosure of 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, QIM may decline to provide treatment to me.

Please share all information regarding my health and medical care with Quality Internal Medicine with the following people:

Name _____ **Relation** _____ **Phone** _____

Name _____ **Relation** _____ **Phone** _____

Mail Order Pharmacy Name/Address/Phone #/Fax #:_____

_____

Local Pharmacy Name/Address/Phone#/Fax#:_____

_____

I agree that my signature may be stored electronically as an original.

_____ _____ _____

Signature of Patient or Legal Guardian | Patient's AND Legal Guardian's Name | Date