FIRST CARE SERVICES
DEVOTED CARE WITH GRACIOUS HANDS
2501 STIRRUP LANE ALEXANDRIA VA 22308 | TEL: (571) 336-2287 | FAX: (877) 543-9437

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for _____ 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 _____describes such uses and disclosure's more completed.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. _____reserve 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 _____.

With this consent, Holy Health Care Services may call my home or other alternative location and leave a message on voicemail or in person in reference to any item that assist the practice in caring out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory test results, among others.

With this consent Holy Health Care Services may mail to my home or other alternative location any items that assist the practice in carrying TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Holy Health Care Services, Inc. may e-mail to my home or other alternative location any items that assist the practice I carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Holy Health Care Services restricts 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 Holy Health Care Services 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, Holy Health Care Services may decline to provide treatment to me.

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_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Legal Guardian if applicable