Preventive Cardiology & Internal Medicine Associates, P.L
3606 Maclay Blvd, Suite 104 Tallahassee FL 32312

Patient Consent for Use and Disclosure of Protected Health Information (HIPPA)

I hereby give my consent for PCAIMA to use and disclose protected health information (PHI) about me to carry out treatment payment and healthcare operations (TPO) (PCAIMA's Notice of Privacy Practices provides a more complex description of such uses and disclosures).

I have the right to review the Notice of Privacy Practices prior to signing this consent. PCAIMA 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 Preventive Cardiology & Internal Medicine Associates, 3606 Maclay Blvd. Suite 104, Tallahassee, FL 32312.

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

Home/Work/Email: ____

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With this consent, PCAIMA may call my:

Cell:___________________________

Home:____________________________

Work:____________________________

Any items that assist the practice in carrying out TPO, such as appointment reminders, clinical information, billing and insurance statements, etc. as long as they are marked personal and confidential. If you would like to communicate with us via email in a secure fashion, please sign up to use our Patient Portal for a nominal fee.

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

I have the right to request that PCAIMA 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 PCAIMA'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, PCAIMA may decline to provide treatment to me.

ADDITIONALLY, our office will be actively involved in local medical school teaching programs. Our providers feel that it is an obligation inherent to the profession of medicine and an important service we must provide for the betterment of the profession. It is only through our patients' willingness and enthusiasm to participate in the mentoring of medical students that we can enhance the teaching process here at PCAIMA. Thank you! Please indicate below if and how you would like to help us in this mission realizing that our providers will be supervising and also examining you at the time of such encounter.

____ I do NOT want to have medical students or residents participate in my care under any circumstances.

____ I am willing to have such trainees participate in my care unless I indicate otherwise at the time I arrive for my appointment.

PLEASE INDICATE YOUR PREFERRED PHARMACIES:

Mail-Order Pharmacy Name/Address/Phone/Fax#: ____

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

____

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

____ _________________________________ __________________

Signature of Patient/Legal Guardian | Patient's (AND legal Guardian's) Name | Date