Primary Care Physicians of Stow, LLC

Patient Consent for Use and Disclosure
of Protected Health Information

I hereby give my consent for Primary Care Physicians of Stow 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 Primary Care Physicians of Stow describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Primary Care Physicians of Stow 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 Pennie Marchetti, MD, 1355B Corporate Drive, Hudson, Ohio 44236.

With this consent, Primary Care Physicians of Stow may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment, and health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Primary Care Physicians of Stow may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Primary Care Physicians of Stow may e-mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards and patient statements. I have the right to request that Primary Care Physicians of Stow restrict how it uses or discloses my protected health information to carry out treatment, payment, and healthcare operations. 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 Primary Care Physicians of Stow to use and disclose my protected healthcare information to carry out treatment, payment, and healthcare operations.

Please note that Primary Care Physicians of Stow uses the phone number(s) you give to us each year when you update your personal information. We use that number to call you for appointment reminders, insurance items and any calls pertaining to your clinical care, including laboratory test results, among others. You may, however, specify with whom we speak and at what phone number, when communicating labs, tests, and other medically specific information.

To ensure your confidentiality is protected, please complete the following:

I authorize Primary Care Physicians of Stow to disclose my protected healthcare information to:

Name(s):_____

_____

_____.

I authorize Primary Care Physicians of Stow to leave messages which may contain my protected healthcare information at the following numbers (fill in all that apply)

Home_____

Work_____

Cell _____

Other _____

____ If you prefer to be contacted by mail only, please check here and provide us with your preferred address for contact below:

_____

_____

_____

I may revoke my consent in writing except to the extent that the practice has already made disclosures upon my prior consent. My written revocation must be submitted to the privacy officer at:

Primary Care Physicians of Stow, LLC
1355B Corporate Drive
Hudson, Ohio 44236

If I do not sign this consent, or later revoke it, Primary Care Physicians of Stow may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable