

FIRST CARE PC

Privacy and Disclosure of Private Health Information (PHI)

Printed Name: _____ Date of Birth: _____

Our Notice of Privacy Practices (NPP) provides information about how we may use and disclose your personal health information. By signing below you acknowledge that you have received a copy of our NPP (effective date 9/23/2013).

I consent to receive calls from First Care PC for my protected healthcare and other services at the phone number(s) I listed on the patient registration sheet including my wireless number provided.

I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

I give permission to the person(s) listed below to have access to my Private Health Information and to discuss my medical information with employees of First Care PC.

I understand this form is legally binding and that I may revoke my authorization at any time by submitting by request to change, add or terminate such permission in writing.

<u>Name</u>	<u>Relation to you</u>	<u>Contact Number</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

 Patient or Guardian Signature: Relationship to Patient: Date: