MGH FAMILY HEALTH CENTER
DBA
MUSKEGON FAMILY CARE

PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

I hereby give my consent for **MGH Family Health Center dba Muskegon Family Care** to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

I hereby authorize my insurance benefits to be paid directly to **MGH Family Health Center dba Muskegon Family Care**. I realize that I am responsible to pay any non-covered services.

I have received a copy of MGH Family Health Center dba Muskegon Family Care's Notice of Privacy Practices which 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. **MGH Family Health Center dba Muskegon Family Care** 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 MGH Family Health Center dba Muskegon Family Care Privacy Officer at 2201 S. Getty Street, Muskegon Heights, MI 49444.

With this consent, **MGH Family Health Center dba Muskegon Family Care** 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 TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, **MGH Family Health Center dba Muskegon Family Care** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, **MGH Family Health Center dba Muskegon Family Care** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that MGH Family Health Center dba Muskegon Family Care restrict how it uses or discloses my PHI to carry out TPO.

With this consent, I agree that I have received Patient Center Medical Home informational document from **MGH Family Health Center dba Muskegon Family Care.**

However, 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 **MGH Family Health Center dba Muskegon Family Care** 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, **MGH Family Health Center dba Muskegon Family Care** may decline to provide treatment to me.

_____ _____
Signature of Patient or Legal Guardian Patient's Date of Birth

_____ _____
Patient's Name (Please Print) Signature Date