2121 Whitesburg Dr, Suite C ♦ Huntsville, AL 35801 ♦ www.blossomwoodmedical.com ♦ phone: 883-0107 ♦ fax: 883-0207

Privacy Practices; Consent for Use; Disclosure of Protected Health Information (PHI)

I, ____, was provided with a copy of Blossomwood Medical's Privacy Practices Notification. Blossomwood Medical may revise its notification at any time. I understand that this copy is always available upon request. By signing this document, I acknowledge that I have read, understand, and agree to the terms of the consent. Further, I hereby consent any authorize Blossomwood Medical to use or disclose my PHI in conjunction with Blossomwood Medical's treatment, payment, or healthcare operations in accordance with the terms of this consent.

____ ____

Signature **Date**

I hereby authorize and give my consent to Blossomwood Medical to leave messages on my answering machine/voicemail for the following **(check all that apply)**:

- ☐ Appointment Reminders
- ☐ Medical Information
- ☐ Insurance/Payment Concerns
- ☐ Prescription Refills
- ☐ Test/Lab Results
- ☐ Mail

Furthermore, I authorize and give consent to Blossomwood Medical to communicate any of my PHI to the following person(s):

Name	Relation	Phone Number

____ ____

Signature **Date**