Blossomwood Medical
primary care for adults

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

I, _____, was provided with a copy of Blossomwood Medical's Privacy Practice Notification. Blossomwood Medical may revise its notification at document, 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 and authorize Blossomwood Medical to us 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 to Blossomwood Medical to leave messages on my answering machine / voicemail for the following **(circle 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	Relationship	Contact number
Name	Relationship	Contact number
Name	Relationship	Contact number
Name	Relationship	Contact number

_____ _____

Signature **Date**