BROOKRIDGE INTERNAL MEDICINE ASSOCIATES, P.A.

HIPAA Written Acknowledgement of Privacy Practice

I acknowledge that Brookridge Internal Medicine Associates, PA has provided a written copy of the HIPAA Privacy Practice and I have been given the opportunity to read the Notice of Privacy Practices.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Brookridge Internal Medicine Associates, PA to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). **(Brookridge Internal Medicine Associates, PA's Notice of Privacy Practices 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. Brookridge Internal Medicine Associates, PA 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 Brookridge Internal Medicine Associates, PA's Privacy Officer at 300 N. 3rd St., Longview, Tx. 75601.

With this consent, Brookridge Internal Medicine Associates, PA may call my home or other alternate 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, Brookridge Internal Medicine Associates, PA 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, Brookridge Internal Medicine Associates, PA 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 Brookridge Internal Medicine Associates, PA restrict how it uses or discloses my PHI to carry out TPO. 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 Brookridge Internal Medicine Associates, PA's 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, Brookridge Internal Medicine Associates, PA may decline to provide treatment to me.

I give consent for Brookridge Internal Medicine Associates, PA to give my Protected Health Information to persons listed below (these are people outside of your additional medical providers):

_____

_____

_____ _____

Signature of Patient or Legal Guardian Date

_____

Patient's name (printed)