Medi Clinics Primary Care LLC.

PATIENT CONSENT FOR USE AND DISCLOSUER OF PROTECTED HEALTH INFORMATION
(CONSENT TO DISCLOSE OR TO NOT DISCLOSE HEALTH INFORMATION)

With my consent, **MEDI CLINICS PRIMARY CARE LLC**. May use and disclose **Protected health information (PHI)** about me to carry out **Treatment, Payment and Healthcare operation (TPO).** Please refer to **MEDI CLINICS PRIMARY CARE LLC'S** Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy of Practices prior to signing this consent. **MEDI CLINICS PRIMARY CARE LLC.** reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written letter to

MEDI CLINICS PRIMARY CARE LLC
502 S. MACDILL AVENUE
TAMPA, FL. 33609

With my consent, **MEDI CLINICS PRIMARY CARE LLC.** may call my home or other designated location and leave a message on a voicemail or in person in reference to any items that assist the practice in carrying out TPO, including laboratory and radiography results among others.

With my consent, **MEDI CLINICS PRIMARY CARE LLC.** may mail to my home or other designated location any items that assist the practice in carrying out TPO as noted above as long as they are marked Personal and Confidential.

With my consent, **MEDI CLINICS PRIMARY CARE LLC.** may email any items that assist the practice in carrying out TPO as noted above.

I have the right to request that **MEDI CLINICS PRIMARY CARE LLC.** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

Please note any form of communication or any person with whom **MEDI CLINICS PRIMARY CARE LLC.**
□ **MAY NOT** communicate with, in regards to patient's personal health information

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□ **MAY** communicate with, in regards to patient's personal health information

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By signing this form, I am consenting to **MEDI CLINICS PRIMARY CARE LLC'S** use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the practice who have already made disclosures in reliance upon my prior consent. If I do sign this consent, **MEDI CLINICS PRIMARY CARE LLC.** may decline to provide treatment to me.

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Signature of Patient or Legal Guardian	Patient's Name	
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Print name of Patient or Legal Guardian	Patient's Date of Birth	Date