PHA ADULT MEDICINE
DELIVERING THE CARE YOU NEED
Text PHA to 55469

1740 South Street, Suite 300, Philadelphia, PA 19146
TEL: 215-732-0876
FAX: 215-732-1812
WEBSITE: www.phaadultmedicine.com
Download: Healow App for Patient Portal

FORM 3: Patient Consent for Use and Disclosure of Protected Health Information and Communication from PHA-Adult Medicine about Medical Information

I hereby give my consent for Philadelphia Health Associates - Adult Medicine, P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

In general, the Health Insurance Portability & Accountability Act (HIPAA) privacy rule gives me the right to request a restriction on uses and disclosures of my protected health information (PHI). Also, I have the right to request confidential communications or that a communication of PHI is made by alternative means. The practice is not required to agree to my requested restrictions if such restrictions inhibit ability to carry out TPO; otherwise, it is bound by this agreement. **I wish to be contacted in the following manner (check all that apply):**

- **Home Telephone**
  - __O.K. to leave message with DETAIL information
  - __Leave message with call-back number ONLY

I want **written communication**
- ____MAIL to my home
- ____FAX to home
- ____MAIL to work
- ____FAX to work

- **Work Telephone**
  - ___ Leave message with DETAIL information
  - ___Leave message with call-back number ONLY

In the event I cannot be reached, I give permission to release information to the following:

Name _____

Relationship _____

Phone _____

PLEASE TURN OVER AND COMPLETE OTHER SIDE

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PLEASE READ AND INITIAL

_____ **(INITIAL**) I understand that I may need to complete Authorization to Release Medical Information before certain forms or information is completed on my behalf to be released to a Third Party.

_____ (**INITIAL**) When I do request communication to be faxed to me, it is my responsibility to ensure that access is secure to keep my protected health information private.

_____ (**INITIAL**) I understand that if I need forms to be completed, I must complete my section first before leaving for the doctor to complete.

_____ (**INITIAL**) I understand there is a charge to complete forms. Failure to pay may result in my losing the privilege of having such services provided to me. Payment Policy applies.

_____ (**INITIAL**) I give permission to complete Utility forms (PGW, PECO, GAS) that I may need completed in order to continue services for medical reasons. I understand that there is a charge to complete such forms. Payment Policy applies.

_____ (INITIAL) I have received a copy of The Notice of Privacy Practices.

_____ (**INITIAL**) I acknowledge that I understand the above and any questions I may have had were answered to my satisfaction. I understand that a photocopy or electronically stored copy of this signed document is as valid as the original.

_____ (**INITIAL**) I may revoke my consent in writing except to the extent that The Practice has already made disclosures in reliance upon my prior request. If I do not sign this consent, or later revoke it, Philadelphia Health Associates - Adult Medicine may decline to provide services to me.

_____	_____	_____
Patient/Guardian/Surrogate Decision Maker	Signature	Date