

Osteopathic Center for Family Medicine  
603 Main Road North  
Hampden, ME 04444  
[www.ocfm.com](http://www.ocfm.com)  
(207) 945-5400

**PATIENT CONSENT FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

I hereby give my consent for Osteopathic Center for Family Medicine to use and disclosed protected health information (PHI) about me to carry out treatment, payment and health care operation (TPO). The Notice of Privacy Practices provided by Osteopathic Center for Family Medicine describes such uses and disclosures more completely.

I acknowledge the receipt of the Privacy Practice or acknowledge that I have refused a copy of the Privacy Practices. Osteopathic Center for Family Medicine reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarded a written request to Osteopathic Center for Family Medicine at the above address.

With this consent, Osteopathic Center for Family Medicine may call my home or other alternative location as delineated below 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 test results, among others.

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Name of Person or Persons

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Address

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Relationship to Patient

With this consent, Osteopathic Center for Family Medicine may mail or email to my home or other alternative location any items that assist the practice in carry out TOP, such as appointment reminder cards and patient statements.

I have the right to request that Osteopathic Center for Family Medicine restrict how it uses or discloses my PHI to carry TPO. The practice is not required to agree to my requested restrictions.

Restrictions:

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**AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)**

By initialing the appropriate line(s) below, Osteopathic Center for Family Medicine has permission to use and disclose the following information during the course of my clinical treatment, payment and healthcare operations.

\_\_\_\_\_ AIDS/HIV testing and treatment

\_\_\_\_\_ Psychiatric/Psychological problems

\_\_\_\_\_ Osteopathic Center for Family Medicine participates in research studies. By initialing this line you are allowing us to contact you regarding any studies that you might be eligible for.

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· This release will stay in affect for 30 months unless revoked by me in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Print name of Legal Guardian, if applicable

\_\_\_\_\_  
Print Patient's Name