Trinity Family Physicians

1817 Cypress Brook Drive Trinity, Fl 34655
Office: 727-834-8377 Fax: 727-834-8371

HIPAA Consent & Notification

I hereby give my consent for **Trinity Family Physicians** to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). **Trinity Family Physicians'** 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.

Trinity Family Physicians reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Trinity Family Physicians,** 1817 Cypress Brook Drive, Suite 101, Trinity, Florida 34655.

With this consent **Trinity Family Physicians** may call my home or alternative 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, **Trinity Family Physicians** may discuss my medical records with:

Name:_____Relationship:_____Telephone:_____
Name:_____Relationship:_____Telephone:_____
Name:_____Relationship:_____Telephone:_____

With this consent, **Trinity Family Physicians** 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, **Trinity Family Physicians** 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 **Trinity Family Physicians** 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 **Trinity Family Physicians'** 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, **Trinity Family Physicians** may decline to provide treatment to me.

____ **I have received a copy of Trinity Family Physicians' Notice of Privacy Practices.**
Initial

Signature of Patient or Legal Guardian: _____

Print Name of Patient or Legal Guardian: _____