Chart Number ___________

PHYSICIANS' CENTER, P.A.

Patient Consent Form

In April of 2003, new federal requirements regarding privacy of information for health care patients take effect. H.I.P.P.A., the Health Insurance Portability and Protection Act requires that all medical providers, insurance companies and others, put in place controls to ensure that your personal medical information is safe.

Physicians' Center requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Signature of Patient or Representative: __________________________ Date _________________

Name of Patient or Representative: __________________________Date of Birth ______________

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request the results of tests and procedures. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your test results released to family members you must sign this form. Signing this form will only give consent to release laboratory and radiology results to the family members indicated below. This consent form will not allow Physicians' Center to release any other information to these family members.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Physicians' Center to release my laboratory/radiology results and reports to the following individuals.

1. _________________________ Relation to Patient: __________________ Date:______________

2. _________________________ Relation to Patient: __________________

PATIENT NAME: ___________________________PATIENT SIGNATURE : ____________________

Authorization to Leave Messages with Household Members/Answering Machine

From time to time it is necessary for representatives of Physicians' Center to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss lab or procedure results, or to ask a patient to call Physicians' Center regarding an issue or concern. At no time will a representative of Physicians' Center discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Name:____

Patient Signature:____________________________________Date:_______________________