EXHIBIT 5

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Practice Name

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, ___________________________ may use and disclose protected health information
Practice Name
(PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to
_________________________'s Notice of Privacy Practices for a more complete description of such
Practice Name
uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.
___________________________ reserves the right to revise its Notice of Privacy Practices at
Practice Name
anytime. A revised Notice of Privacy Practices may be obtained by forwarding a
written request to ________________________Privacy Officer at [*Street Address, City, State Zip*].
Practice Name

With my consent, ___________________________ may call my home or other designated location
Practice Name
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 call pertaining to my clinical care, including laboratory results among others.

With my consent, _____________________ may mail to my home or other designated location any
Practice Name
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 my consent, ___________________________ may e-mail to my
Practice Name
home or other designated 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
___________________________ restrict how it uses or discloses my PHI to carry out TPO.
Practice Name
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 ________________________’s use and disclosure of my

Practice Name

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, ________________________ may decline to provide treatment to me.

Practice Name

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Signature of Patient or Legal Guardian

______________________________ ____________________

Patient’s Name Date

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Print Name of Patient or Legal Guardian