Piedmont Psychiatric Associates, PA
Hayne D. McMeekin, MD

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name: _____ Date of Birth: _____

Mailing Address): _____

City _____ State _____ Zip Code _____

Telephone: (Daytime) _____ (Evening)_____

By signing this form, you grant Piedmont Psychiatric Associates, PA (*the Practice*) and Hayne D. McMeekin, MD consent to use and disclose your protected health information for the purposes of treatment, payment and healthcare operations as described in our *Notice of Privacy Practices* (*Notice*). Our *Notice* provides a description of our uses and disclosures regarding your protected health information and your health information rights.

With this consent, you are granting permission for *the Practice* to call your home, or other designated location and leave a message, in person or by voice mail, in reference to any items that assist the practice in carrying out your treatment, payment activities or healthcare operations. This may include, but not be limited to, appointment reminders, insurance items, prescription information or any call pertaining to your clinical care. This consent also allows for e-mail communication regarding treatment, payment activities or health care operations. You are also granting permission for us to with your designated emergency contact person when needed.

The Practice may not be able to agree with every special restriction request regarding use or disclosure of your protected healthcare information. However, if granted we are bound by such agreement.

The Practice reserves the right to revise our privacy practices as described in our *Notice of Privacy Practices.* If we change our privacy practices, we will issue a revised *Notice of Privacy Practices,* which will contain any changes.

Right to Revoke: You will have the right to revoke this *Consent* at any time, except to the extent that *the Practice* has already made disclosures in reliance upon prior consent. A refusal to sign this *Consent* or a revocation may result in refusal or discontinuation of treatment.

I have been provided an opportunity to review the *Notice of Privacy Practices* and I understand that I will be provided a copy, upon request, before signing this *Consent.*

In addition, information pertaining to my clinical care, payment activity, insurance and medication management my be disclosed to the following persons:

_____ _____

X_____ _____
Signature **Date**

If, on behalf of the patient, a personal representative signs this *Consent*, please complete the following:

Representative's Name:_____Relationship to patient: _____

You may obtain information regarding our *Notice to Privacy Practices,* as well as additional copies and any revisions by contacting our office at (803)-548-4669.

Upon request you are entitled to a copy of this consent after you sign it

The following statement is to be signed only if you decide to revoke your Consent agreed to by the signature above.

Revocation of Consent

I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations.

I understand the revocation of my Consent will not affect any action taken in reliance on my consent before you received my written Notice of Revocation. I also understand that I may be declined treatment as a result of my revocation of Consent.

Signature_____ Date_____