Atlanta Medical Arts and Wellness, LLC

Patrice Y. Marshall, M.D.
2784 N. Decatur Road
Suite 100
Decatur, GA 30033

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Atlanta Medical Arts and Wellness, LLC** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **Atlanta Medical Arts and Wellness, LLC** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.
Atlanta Medical Arts and Wellness, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Patrice Y. Marshall, M.D. at Atlanta Medical Arts and Wellness, LLC, 2784 N. Decatur Road, Suite 100, Decatur, GA 30033.**

With this consent, **Atlanta Medical Arts and Wellness, LLC** may call my home or other 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 test results, among others.

With this consent, **Atlanta Medical Arts and Wellness, LLC** 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, **Atlanta Medical Arts and Wellness, LLC** 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 **Atlanta Medical Arts and Wellness, LLC** restrict how it uses or discloses my PHI to carry out TPO. 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 allow **Atlanta Medical Arts and Wellness, LLC** to use and disclose 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, **Atlanta Medical Arts and Wellness, LLC** may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable