Patient Consent For Use and Disclosure of Protected Health Information

I hereby give my consent for Psych Care Associates, P.C. 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 Psych Care Associates, P.C. describes such uses and disclosures more completely).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Psych Care Associates, P.C. 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: Usman Qayyum, M.D., Medical Director, 185 West Avenue, Suite 301, Ludlow, Ma 01056.

With this consent, Psych Care Associates P.C. may call my home or other alternative location and leave a message on voicemail 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 testing results, among others.

With this consent, Psych Care Associates, P.C. may email my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder calls and patient statements. I have the right to request that Psych Care Associates, P.C. 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 Psych Care Associates, P.C. 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, Psych Care Associates, P.C. may decline to provide treatment to me.

☐ I received the Notice of Privacy Practices and member rights provided by Psych Care Associates, P.C.

Signature:_____ Date:_____

Relationship to Patient:_____

Patient's Name (please print):_____

Name of Legal Guardian (please print):_____

Consent to Call:
When sending artificial, pre-recorded, or automated calls and text messages, we now require receipt of prior written and/or oral consent. Kindly provide your consent by signing below.

Signature:_____ Date:_____