PCI Use Only

PIEDMONT CANCER INSTITUTE PC

Patient Acknowledgement / Consent Form

I hereby give my consent for Piedmont Cancer Institute, P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent (a copy is in the reception area and a copy may be requested from the receptionist). Piedmont Cancer Institute, P.C.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures.

Piedmont Cancer Institute, 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:

Piedmont Cancer Institute, P.C.
Privacy Officer / Human Resources
1800 Howell Mill Rd NW, Suite 800
Atlanta, GA 30318-0922
Telephone: 404-350-9853

With this consent, Piedmont Cancer Institute, P.C., may call my home or mail to my home or other alternative location any items that assist the practice in carrying out TPO such as appointment reminders, insurance items or patient statements, as well as any calls, or printed information pertaining to my clinical care, including laboratory results among others.

Electronic Communication/Email Notice – we provide **Navigating Care™,** a secure patient portal, as a convenience to our patients for electronic communication between you and PCI to ensure protected health information (PHI) is secured to prevent unauthorized individuals from intercepting messages. If you choose to electronically communicate/email us outside of **Navigating Care™**, your email information will not be secure. PCI will not electronically communicate/email PHI information to you that is not secure unless we have detailed written authorization from you on file prior to submission.

I have the right to request that Piedmont Cancer Institute, P.C., restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound to this agreement.

By signing this form, I am consenting to Piedmont Cancer Institute, P.C.'s use and disclosure of my PHI to carry out TPO. I hereby release Piedmont Cancer Institute, P.C.'s and its agents and employees from any and all liabilities, damages, losses, claims and expenses which may arise from the release of the information authorized above.

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, Piedmont Cancer Institute, P.C. may decline to provide treatment to me. A photocopy of this document shall be as valid as the original.

Signature of Patient or Legal Guardian	Relationship to Patient	Date of Birth
Print Patient's Name or Legal Guardian	Date	

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Consent for Disclosure

Family Member and/or Personal Representative

Patient Full Legal Name: _____ DOB: _____

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for **Piedmont Cancer Institute, P.C.** and Dr.(s):

Choose all that apply

☐ Dr. Nakita Amin	☐ Dr. Trevor Feinstein	☐ Dr. Eric Mininberg	☐ Dr. Samantha Shams
☐ Dr. Vasily Assikis	☐ Dr. William Jonas	☐ Dr. Minesh Patel	☐ Dr. Rajni Sinha
☐ Dr. Jonathan Bender	☐ Dr. Vipin Lohiya	☐ Dr. Jay Rhee	☐ Dr. Ha Tran

and his or her staff to disclose my personal information to the following individual(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Conditions for Disclosure (check the item(s) that apply):

☐ The practice may disclose my personal health information to the above individual(s) **only** in my presence.

☐ The practice may disclose my medical information to the individual(s) above in discussions in my presence and when I am not physically present, including disclosures by telephone, facsimile, e-mail or regular mail.

☐ Other condition(s) of disclosure:

_____

I authorize for **Piedmont Cancer Institute, P.C.** to communicate with me regarding my **Private Health Information (PHI)** in the following manner (please check the item(s) that apply):

Leave message on my voicemail/cell phone	☐ Yes	☐ No
Leave message with a family member	☐ Yes	☐ No
Leave message with my employer	☐ Yes	☐ No
Email/Electronic Communication - using Patient Portal – Navigating Care™ (secure)	☐ Yes	☐ No

I understand that this consent may be revoked by me at any time by written notice to the practice.

Patient Signature: _____ Date: _____

Witnessed by Signature: _____ Title/Position: _____

Printed Name of Witness: _____ Date: _____