

Preston Medical Associates  
110-A Preston Executive Drive  
Cary, NC 27513  
(919)319-9219- phone  
(919)481-1716- fax

Consent to Use or Disclose Information for Treatment, Payment health Care Operations,  
or other Uses Permitted Under HIPAA

The patient hereby consents to the use or disclosure of his/her individually identifiable health information "protected health information" by Preston Medical Associates(PMA) in order to carry out treatment, payment or health care operations. The patient should review our Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information and the Patient has the right to review such notice prior to signing this consent form.

Preston Medical Associates reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If we do change the terms of its Notice of Privacy Practices, Patients may obtain a copy of the revised Notice at the reception desk, or mailed to you.

Patient retains the right to request that PMA further restrict how his/her protected health information is used or disclosed to carry out treatment, payment or health care operations. PMA is not required to agree to such requested restrictions; however, if PMA does agree to your requested restriction(s), such restrictions are then binding on PMA.

At all times, the Patient retains the right to revoke this consent. Such revocation must be submitted us, PMA in writing. The revocation shall be effective expect to the extent that PMA has already taken action in reliance on the consent.

PMA may refuse to treat the Patient if he/she (or an authorized representative) does not sign this consent form (except to the extent that PMA is required by law to treat individuals). If the Patient (or authorized representative) signs this consent form and then revokes consent, PMA has the right to refuse to provide further treatment to the Patient as of the time of revocation (except to the extent that PMA is required by law to treat individuals).

**I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.**

**Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **AM/PM**

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**Signature of Patient (or authorized representative)**

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**Please Print Name of Patient**  
\_\_\_\_\_ **employee initial**

