PRIMARY MEDICINE, LLC

Patient Acknowledgement and Consent for Use and Disclosure

Of Protected Health Information

I hereby give my consent for Primary Medicine and its affiliates, to use and disclose protected health Information (PHI) about me to carry out treatment, payment, and health care operations (TPO). * For complete information on Use and Disclosures, please see The Notice of Privacy Practices provided by Primary Medicine.*

I have the right to review the Notice of Privacy Practices prior to signing this consent and have been provided the opportunity to review it. Primary Medicine 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 the attention of the Privacy Officer, at the office address.

By signing this form, I am consenting to allow Primary Medicine to use and disclose my PHI to carry out Treatment, Payment, and Healthcare operations.

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, Primary Medicine, may decline to provide treatment to me.

__________________________________ __________________________________

Signature of Patient or Legal Guardian Print Name if Legal Guardian

__________________________________ __________________________________

Print Patient's Name Date

**For Office Use Only* I attempted to obtain the patients signature in acknowledgement on the Notice of Privacy Practices Acknowledgement and Consent, but was unable to do so as documented below:*

Date: ______________ *Reason:* ________________ *Initials:* ____