PATIENT CONSENT- HIPAA

With my consent, JENNIFER CAUDILL, MD PLLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations. Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures- available upon request. Our office 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 office of JENNIFER CAUDILL, MD PLLC.

By signing this form, I am consenting to the use and disclosure of my Protected Health Information (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 prior consent. If I do not sign this consent, JENNIFER CAUDILL, MD may decline to provide treatment to me.

PLEASE CHECK BOXES THAT APPLY:

☐ I **DO** give consent to leave **voicemail messages** on the phone numbers provided regarding results or any medical information about my care, appointments, and payment information.

☐ I **DO** give consent to correspond with the office by **text messages** regarding results or any medical information about my care, appointments, and payment information.

☐ I do **NOT** give consent to leave detailed voicemail and/or text messages. Messages may contain ONLY call back information.

I give special permission to the person(s) named below to receive medical information regarding my care and treatment in this office, including biopsy results, lab results, and other medical information.

NAME	Relationship	Phone

_______________________________________ _______________________

Signature of patient or legal guardian Date

Print name of patient_______________________________