M. D. SAUNDERS, M.D., P.C.

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, M. D. Saunders, M.D., P.C., may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the M. D. Saunders, M.D., P.C. *Notice of Privacy Practices* for a more complete description of such uses and disclosures.

I have the right to review the *Notice of Privacy Practices* prior to signing this consent. M. D. Saunders, M.D., P.C. reserves the right to revise its *Notice of Privacy Practices* at anytime. A revised *Notice of Privacy Practices* may be obtained by forwarding a written request to Marci L. Brooks, Privacy Officer at 3950 Shore Rd., Williamsburg, MI 49690.

With my consent, M. D. Saunders, M.D., P.C., may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, M. D. Saunders, M.D., P.C., may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, M. D. Saunders, M.D., P.C. may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that M. D. Saunders, M.D., 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 by this agreement. By signing this form, I am consenting to M. D. Saunders, M.D., P.C.'s use and disclosure of 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, M. D. Saunders, M.D., P.C. may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Legal Guardian

I give my permission to share my confidential medical information with

NO ONE (circle if applies)

Or

the following individual(s). Please provide the person(s) name and relationship below:

_____ _____

_____ _____