Receipt of Privacy Practices
for John B. Crider, M.D. L.L.C.,
Family Medical Clinic, Arab, AL

Consent for Use / Disclosure of Protected of Health Information (PHI)

I, _____
Printed Name

was provided a copy of John B. Crider, M.D., Family Medical Clinic, L.L.C. (FMC) *Notice of Privacy Practices.* This document is also available for review on the FMC website, *johncridermd.com.* FMC may revise its notification at any time. I understand that a copy is always available at my request. By signing this document I acknowledge that I have read, understand, and agree to the terms of this consent. Further, I hereby consent and authorize FMC to use or disclose my PHI in conjunction with FMC treatment, payment or healthcare operations in accordance with the terms of this consent.

Patient's or Authorized Person's Signature

Signed _____ **Date** _____

Further, I hereby authorize and give my consent to FMC to leave messages on my answering machine / voicemail / email for the following (check all that applies)

___ *Appointment Reminders*
___ *Medical Information*
___ *Insurance / Payment Issues*
___ *Prescription Refills*
___ *Test Results*
___ *Mail*

I further authorize and give consent to FMC to communicate any of my PHI to the following person(s):

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Patient's or Authorized Person's Signature

Signed _____ **Date** _____