COMMONWEALTH PRIMARY CARE, INC.

Physician/Location: ❑ Glen Forest ❑ Ridgefield ❑ Wyndham ❑ RPC ❑ West Creek
❑ Sommerville ❑ Virginia Family Physicians ❑ Commonwealth Extended Care

Name: _____ Date of birth: _____
Last First Middle Suffix

Permission to Discuss PHI: I authorize CPC and its agents to release my protected health information to the following individuals:

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Consent to Treatment: I understand that as part of my healthcare, Commonwealth Primary Care (CPC) originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a **Notice of Privacy Practices** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand CPC reserves the right to change their notice and practices, a current version of which is available on the CPC Web site (http://www.cpcva.com). I also understand that I have the right to restrict how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that CPC is not required to agree to the restrictions requested. I have the right to request to receive confidential communications of protected health information by alternative means or at alternative locations. Such request must be in writing and CPC will accommodate any reasonable requests.

By providing a cell number, I agree that CPC, its affiliates, or those acting on their behalf, may call or text using an automatic telephone dialing system and/or a prerecorded message. With this consent, CPC may call my home, cellular telephone, or other designated location and leave a message on voice mail or in person in reference to any items that assist CPC in carrying out treatment, payment, and operations activities, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results.

With this consent, Commonwealth Primary Care may mail to my home or other designated location any items that assist CPC in carrying out treatment, payment, and operations activities, such as appointment reminders and other correspondence as long as they are marked Personal and Confidential.

With this consent, Commonwealth Primary Care may e-mail to text me appointment reminders and patient statements.

By signing this form, I am consenting to Commonwealth Primary Care's use and disclose my PHI to carry out my treatment, payment, and operations activities.

I may revoke my consent in writing except to the extent that CPC has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, Commonwealth Primary Care may decline to provide treatment to me.**

Insurance Authorization: I authorize the release of any medical information to any insurance company, Medigap Insurance, third party administrator, or other payer that is necessary to process the claim and request payment of benefits either to myself or to CPC. I authorize CPC and its agents to release medical information contained in my medical record to any insurance companies, federal programs or state programs with which I am insured or who are responsible for payment of my claim. If applicable, I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf for any services furnished to me by or in CPC including physician services. I understand that I am financially responsible for all charges, whether or not covered by insurance. Also, if my account has to be turned over to an attorney or collection agency for collections, I agree to pay all costs of collection including attorneys' fees.

Assignment of Benefits: In consideration for healthcare and subsequent services provided to me by CPC, I hereby assign to CPC and any holder of medical or other information about me, and their agents, any and all rights, benefits, and claims I may have under any policy of insurance and the proceeds from any claim that I may have for injuries. Such assignment hereby authorizes direct payment to CPC under and/or from any such policy of insurance or proceeds.

I certify that I have reviewed this document in full, understand its terms, and have had the opportunity to ask questions regarding its contents. I understand that this document is valid and remains in effect unless revoked in writing by me.

PRINT PATIENT NAME: _____

PATIENT SIGNATURE _____DATE _____

PARENT/GUARDIAN NAME (PRINT) _____
(If Patient is a minor, under age 18)

PARENT/GUARDIAN SIGNATURE _____DATE _____