

**CROSSROADS MEDICAL GROUP, PLLC  
PO BOX 1669  
WHITE HOUSE, TN 37188**

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**PATIENT CONSENT FOR PHYSICIAN TO USE OR DISCLOSE HEALTH CARE INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE**

Patient Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I understand that my health information is private and confidential. I understand that the physicians and staff of Crossroads Medical Group work very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that signing this document means that Crossroads Medical Group may use and disclose my personal health information to help provide my healthcare, to handle my billing and payment and to take care of other healthcare operations.

Crossroads Medical Group has a detailed document called the "Notice of Privacy Practices." It contains more information about policies and practices used to protect our patient's privacy. I understand that I have the right to read the "Notice of Privacy Practices" before signing this agreement. The notice is posted in the office of Crossroads Medical Group. A written copy will be provided upon request. Crossroads Medical Group may update the "Notice of Privacy Practices." A copy of the most recent update is available upon request.

Under the terms of this consent, I can ask Crossroads Medical Group to restrict how my personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that Crossroads Medical Group does not have to agree to my request. If Crossroads Medical Group does agree to my request, I understand that agreed limits would be followed.

I understand that I have the right to cancel this consent in writing to the Privacy Officer of Crossroads Medical Group. If I do cancel the consent, I understand that Crossroads Medical Group may have used or disclosed information about me and canceling this consent would not apply to information already used or disclosed.

I understand that if I cancel this consent, Crossroads Medical Group does not have to provide further healthcare services to me.

My signature below indicates that I have been given the opportunity to review a current copy of the Crossroads Medical Group "Notice of Privacy Practices."

\_\_\_\_\_  
Patient or legally authorized signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient