DC MEDICAL SERVICES, LLC.
SEAFORD INTERNAL MEDICINE, LLC.

Patient Consent for Use and Disclosure of Protected Health Information

The individual whose signature appears below hereby attests to the following statements:
With my consent, DC MEDICAL SERVICES, LLC and SEAFORD INTERNAL MEDICINE, LLC, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Please refer to DC MEDICAL SERVICES, LLC and SEAFORD INTERNAL MEDICINE LLC'S Notice of Privacy Practices for a more complete description of such uses and disclosures.)

With my consent, DC MEDICAL SERVICES, LLC and SEAFORD INTERNAL MEDICINE, LLC may disclose my PHI to the following individuals (family, relatives, or friends) who may assist in my care:

Name	Relationship	Home #:	Work #:	Cell #:

Please indicate name, contact numbers, and relationship of individuals to whom DC MEDICAL SERVICES, LLC and SEAFORD INTERNAL MEDICINE, LLC may release PHI.

I have the right to review the Notice of Privacy Practices prior to signing this consent. DC MEDICAL SERVICES, LLC and SEAFORD INTERNAL MEDICINE, LLC reserves the right to revise its Notice of Privacy Practices at anytime. A written copy of our Notice of Privacy Practices may be obtained by forwarding a written request to our office.

CONSENT FOR CALLS TO HOME
With my consent DC MEDICAL SERVICES, LLC and SEAFORD INTERNAL MEDICINE, LLC may call my home or other designated location and leave message on my voice mail or with a person in reference to any item that may assist DC MEDICAL SERVICES, LLC and SEAFORD INTERNAL MEDICINE, LLC in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

CONSENT FOR MAIL
With my consent, DC MEDICAL SERVICES, LLC and SEAFORD INTERNAL MEDICINE, LLC may mail to my home or other designated location any item that may assist DC MEDICAL SERVICES, LLC and SEAFORD INTERNAL MEDICINE, LLC in carrying out TPO such as appointment reminder cards and patient statement as long as they are marked CONFIDENTIAL.

CONSENT FOR E-MAIL
With my consent, DC MEDICAL SERVICES, LLC and SEAFORD INTERNAL MEDICINE, LLC may e-mail to my designated e-mail address any message in reference to any item that may assist in my care.

DC MEDICAL SERVICES and SEAFORD INTERNAL MEDICINE, LLC may contact me for TPO use, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

I have the right to request DC MEDICAL SERVICES, LLC and SEAFORD INTERNAL MEDICINE, LLC restricts how it uses or discloses my PHI to carry out the TPO, However,
DC MEDICAL SERVICES and SEAFORD INTERNAL MEDICINE, LLC 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 DC MEDICAL SERVICES, LLC and SEAFORD INTERNAL MEDICINE, LLC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that DC MEDICAL SERVICES, LLC and SEAFORD INTERNAL MEDICINE, LLC has already made disclosure in reliance upon my prior consent. If I do not sign this consent, DC MEDICAL SERVICES, LLC and SEAFORD INTERNAL MEDICINE, LLC may decline to provide services to me.

Signed by: _____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Date

_____
Printed Name of Patient or Legal Guardian

PATIENT/GUARDIAN WILL BE PROVIDED WITH A SIGNED COPY OF THIS AUTHORIZATION)