James Gronemeyer, DO
290 Massachusetts Avenue, Ste 1
Arlington, MA 02474

Patient Consent For Use and Disclosure Of Protected Health Information

With my consent James Gronemeyer, D.O. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. James Gronemeyer, D.O. reserves the right to revise its Notice of Privacy Practices at anytime. These will be made available upon a written request to the office.

With my consent, James Gronemeyer, D.O. or employees of the practice 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, James Gronemeyer, D.O. or employees of the practice 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 as long as they are marked Personal and Confidential.

With my consent, James Gronemeyer, D.O. or employees may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders or patient statements. I have the right to request that James Gronemeyer, D.O. 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 James Gronemeyer, D.O. 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, James Gronemeyer may decline to provide treatment to me.

Signature of Patient or Legal Guardian
Print Name of Patient or Legal Guardian----------Date----------