ALPHA FAMILY MEDICINE INC.

Enhancing Life & Excelling in Care
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Tel: 678-619-1974 ❖ Fax: 678-619-1975
www.alphafammed.com

COMMUNICATION DIRECTIVE & CONSENT FOR TREATMENT
(must be signed and dated before treatment)

Please indicate how you would like us to send your confidential health care information: Choose all that apply:

☐ Patient Portal Account ☐ Home Phone ☐ Cellphone ☐ Work Phone

You may leave a phone message on my answering machine/voicemail at:

☐ Home ☐ Cell ☐ Work ☐ With another person at: ______________________________

CONSENT FOR TREATMENT:

1. CONSENT TO DIAGNOSTIC TESTS, PROCEDURES AND TREATMENT:

I consent to care involving routine diagnostic tests, procedures and treatment as performed or ordered by the clinicians at Alpha Family Medicine Inc, including their assistants or designees. No guarantee has been given to me as to the results that may be obtained from my care.

2. CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR MEDICAL TREATMENT

I consent to Alpha Family Medicine Inc (AFM), using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to AFM using or disclosing my protected health information for treatment activities provided by another health care provider as well as payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

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Signature (Patient/Guardian/Power of Attorney) Today's Date

The undersigned certifies that the patient is a minor or unable to consent and certifies that he/she has read and agrees to the above as the responsible party of the patient.

____ ____________________

Responsible Party Signature Today's Date