David S. Jones M.D. P.C.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for David S. Jones M.D. P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices Provided by David S. Jones M.D. P.C._____(initials)

I have the right to review the Notice of Privacy Practices prior to signing this consent. David S. Jones M.D. P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Attn: Privacy Officer for the Practice
David S. Jones M.D. P.C.
595 N. Main St. Suite 2
Ashland, Or. 97520

With this consent David S. Jones M.D. P.C. may call my home or other alternative 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 calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, David S. Jones M.D. P.C. may mail to my home or other alternative 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 this consent David S. Jones M.D. P.C. may e-mail to my home or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that David S. Jones M.D. P.C. restrict how it uses or discloses my PHI to carry out TPO. 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 allow David S. Jones M.D. P.C. to use and disclose 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, or later revoke it, David S. Jones M.D. P.C. may decline to provide treatment to me.

Signed by:_____ _____ _____

Signature of Patient or Legal Guardian Date Relationship to Patient

_____ _____

Print Patient's Name Print Name of Legal Guardian, if applicable

Patient/guardian must br provided with a signed copy of this authorization form