Prime Healthcare Providers, PLLC / Phillip Weinstein, M.D., PA

902 Frostwood, Suite #262
Houston, Texas 77024

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, **Prime Healthcare Providers, PLLC / Phillip Weinstein, M.D., PA** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **Prime Healthcare Providers, PLLC / Phillip Weinstein, M.D., PA**'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Prime Healthcare Providers, PLLC / Phillip Weinstein, M.D., PA** reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Prime Healthcare Providers, PLLC / Phillip Weinstein, M.D., PA
Attn: Angela Gomez / Privacy Officer
902 Frostwood, Suite #262
Houston, Texas 77024

1. With my consent, **Prime Healthcare Providers, PLLC / Phillip Weinstein, M.D., PA**., 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.
2. With my consent, **Prime Healthcare Providers, PLLC / Phillip Weinstein, M.D., PA**. 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.
3. With my consent, **Prime Healthcare Providers, PLLC / Phillip Weinstein, M.D., PA** may e-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.

I have the right to request that **Prime Healthcare Providers, PLLC / Phillip Weinstein, M.D., PA** 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 **Prime Healthcare Providers, PLLC / Phillip Weinstein, M.D., PA** 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, **Prime Healthcare Providers, PLLC / Phillip Weinstein, M.D., PA** may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

_______________________________ _______________
Print Name of Patient or Legal Guardian Date

_______________________________ _______________
Witness (office use only) Date