

# UNICOI MEDICAL ASSOCIATES

J. W. COLINGER, M.D. ◆ JASON A. COLINGER, D.O.  
ALICE N. ROGERS, FNP ◆ WANDA S. SHELTON, FNP

---

## PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for **Unicoi Medical Associates** to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). **Unicoi Medical Associates** Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Unicoi Medical Associates**, 105 Gay Street, Erwin, TN 37650.

With this consent, **Unicoi Medical Associates** 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 results among others.

With this consent, **Unicoi Medical Associates** 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, **Unicoi Medical Associates** may e-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. I have the right to request that **Unicoi Medical Associates** 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 **Unicoi Medical Associates'** 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, or later revoke it, **Unicoi Medical Associates** may decline to provide treatment to me.

---

Signature of Patient or Legal Guardian

---

Patient's Name

---

Date

---

Print Name of Patient or Legal Guardian

Effective Date: April 15, 2003

# UNICOI MEDICAL ASSOCIATES

## REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

**PATIENT PLEASE NOTE:** THE PRACTICE IS NOT REQUIRED TO AGREE TO YOUR REQUEST.  
PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE  
INFORMATION REGARDING SUCH REQUESTS.

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's Address: \_\_\_\_\_

Street \_\_\_\_\_

Apartment # \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Type of PHI to be restricted or limited: (Please check all that apply)

Home Phone #

Patient History

Home Address

Office Address

Occupation

Office Phone #

Name of Employer

Spouse's Name

Visit Notes

Spouse's Office Phone #

Hospital Notes

Other \_\_\_\_\_

Prescription Information

How would you like your PHI restricted? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_