



ACKNOWLEDGEMENT OF THE RECEIPT OF PRIVACY PRACTICES

I have reviewed the notice of Privacy Practices regarding my Protected Health Information from Meliora Family Medicine PLLC. I hereby give my consent for Jessica Davis, MD to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

With this consent, Jessica Davis, MD 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 items may include appointment reminders and calls pertaining to my clinical care, including laboratory results among others.

With this consent, Jessica Davis, MD may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, laboratory results and patient statements. Electronic mail may be used for these purposes as well.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Jessica Davis MD may decline to provide treatment to me.

I specifically authorize Jessica Davis, MD to communicate issues of my health and medical care with the following persons, if any (Please list contact information):

Patient Name

Date of Birth

Guardian Name (if applicable)

Guardian Relationship

Patient/Guardian Signature

Date

Received by: _____
Jessica Davis, MD

on

Date